

OCHA
Oregon Commission on Hispanic Affairs

Crisis de Nuestro Bienestar*:
A Report on Latino[†] Mental
Health in Oregon



In partnership with



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* Crisis of Our Emotional Well-being

† The term “Latino/a/x” is used in this report because it both conveys respect for the ongoing transformation of community identity, and also includes the whole spectrum of community, including country of origin or ancestry, generation, gender and gender fluidity. Currently, neither of the alternate terms “Latinx” nor “Hispanic” meets this work’s commitment to inclusivity. (“Hispanic” is a generic term for the Latino/a/x community, used by the U.S. Census Bureau to count only Latinos/as/x with Latin American origin or ancestry, and who are Spanish speakers; it thus does not capture the diversity of the Latino/a/x community).

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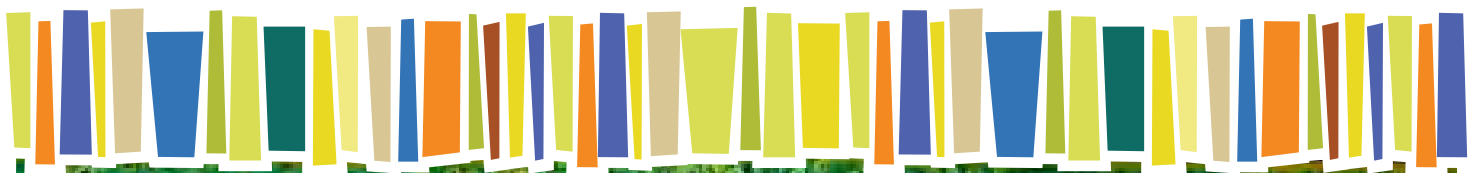
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Executive summary



Hernandez, Hector. (2009). *Monarca Sunrise*. [Acrylic on wall]. Portland, OR. Reprinted with permission.

Executive summary



Why this work is important for all Oregonians

- I. **The Latino/a/x population in Oregon is large and growing; 23% of youth enrolled in Oregon public schools are Latino/a/x. Ensuring access and culturally competent care for this large and growing population is synonymous with ensuring Oregonians' future well-being and success.**

Latinos/as/x comprise the largest minority population in Oregon. The number of Latinos/as/x in Oregon is estimated to be 565,177, more than 13% of the state's population (U.S. Census Bureau, 2019). Seventeen percent, or 86,500, of these Latinos/as/x live in rural counties (see Figure 1) in which access to any mental health providers, especially culturally specific mental health providers, is particularly scarce. (Hernandez, 2018) (See Figure 2).



Our families are, at this time in our history, experiencing tremendous stress loads and tremendous public persecution. This, coupled with geographic and linguistic isolation and a dearth of Latino/a/x mental health providers, threatens to create the perfect mental health storm in our community."

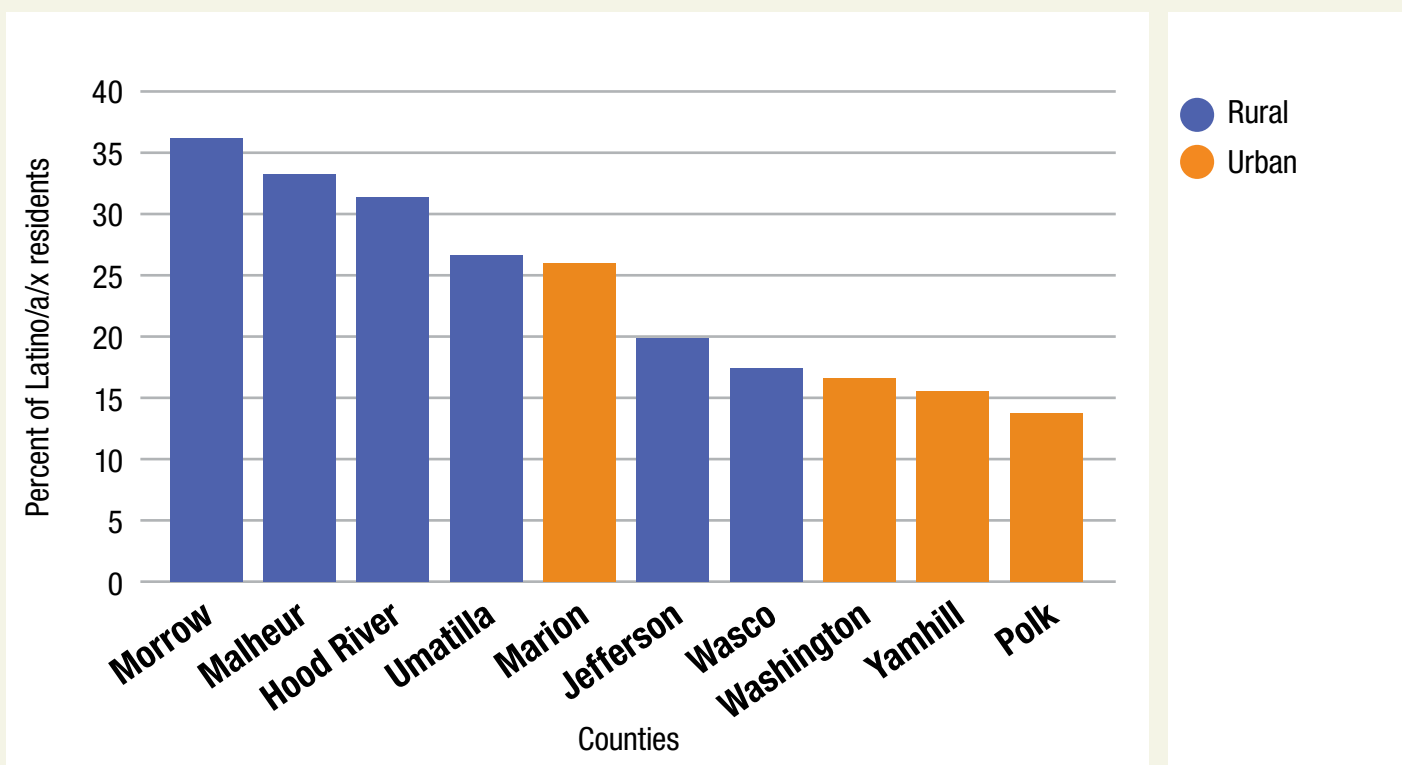
— Alberto Moreno, Chair Emeritus, Oregon Commission on Hispanic Affairs



Figure 1: Lack of licensed and unlicensed behavioral and mental health providers in counties with high percentages of Latinos/as/x

County	Proportion of Latino/a/x residents*	Ratio of residents to full-time licensed behavioral & mental health providers to residents†	Ratio of residents to full-time licensed behavioral & mental health providers, identified by NPI numbers‡, to residents*
Morrow	36.3%	2,818:1	130:1
Malheur	33.1%	1,223:1	200:1
Hood River	31.3%	710:1	290:1
Umatilla	26.4%	1,705:1	260:1
Marion	26.2%	712:1	290:1

Oregon counties with highest Latino/a/x population



Hernandez, 2018

* Oregon Health Authority, Behavioral Health Services

† University of Wisconsin Population Health Institute, 2019

‡ These data come from the National Provider Identification (NPI) data file, which has some benefits and limitations. Providers who transmit electronic health records are required to obtain an NPI. A benefit of using NPIs to identify mental and behavioral health providers is that NPIs capture mental health and behavioral health providers that are not licensed and not full time, likely also capturing providers that are community-based and diverse. Limitations include the following: (1) A very small number of providers may not constitute a number; (2) While providers have the option of deactivating their identification number, some mental health and behavioral health providers included in this list may no longer be practicing or accepting new patients. This may result in an overestimate of active mental health and behavioral professionals in some communities; (3) Mental and behavioral health providers may be registered with an address in one county while practicing in another county. See <https://www.countyhealthrankings.org/app/oregon/2018/measure/factors/56/data>.

Figure 2: Frontier, rural and urban counties in Oregon

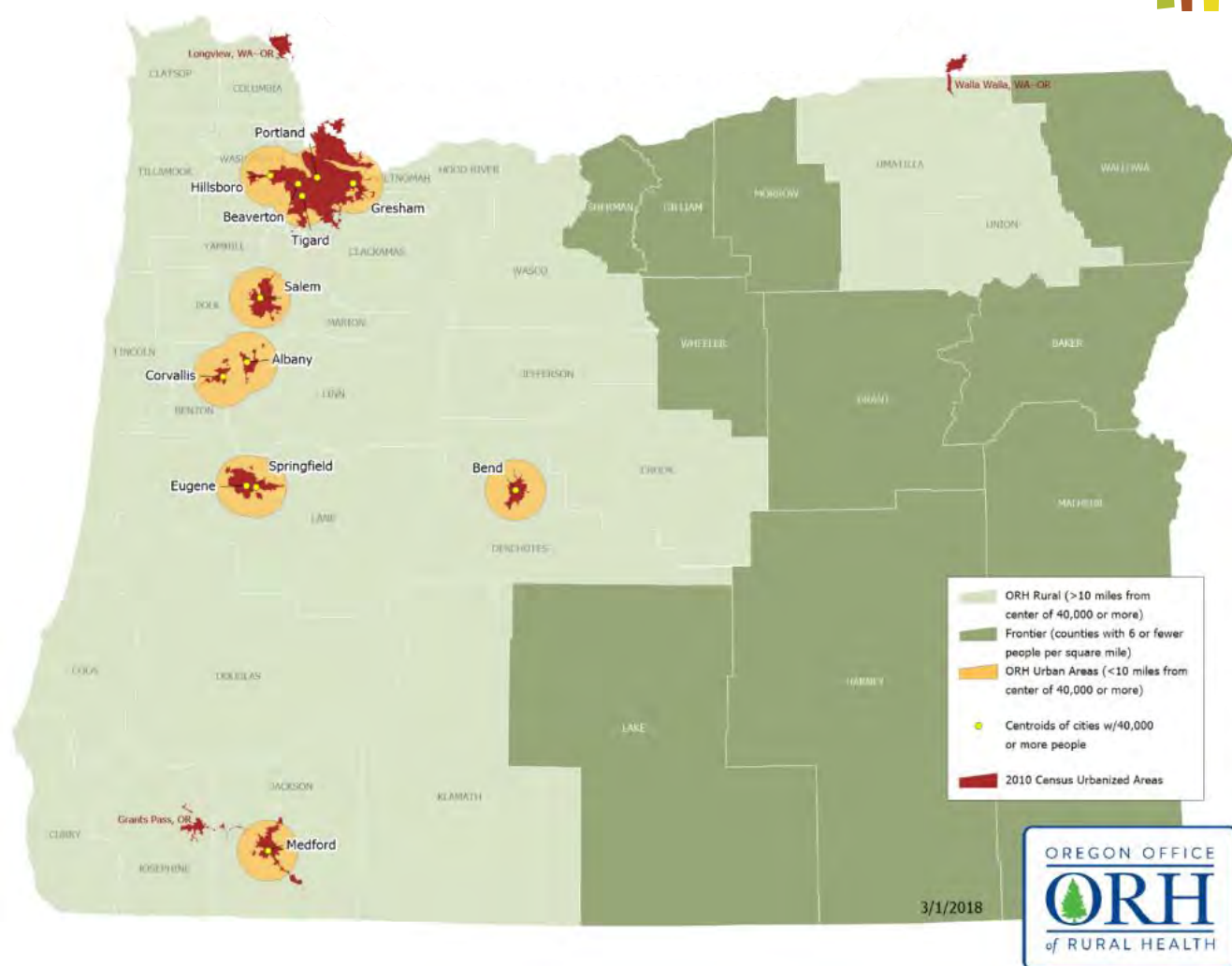
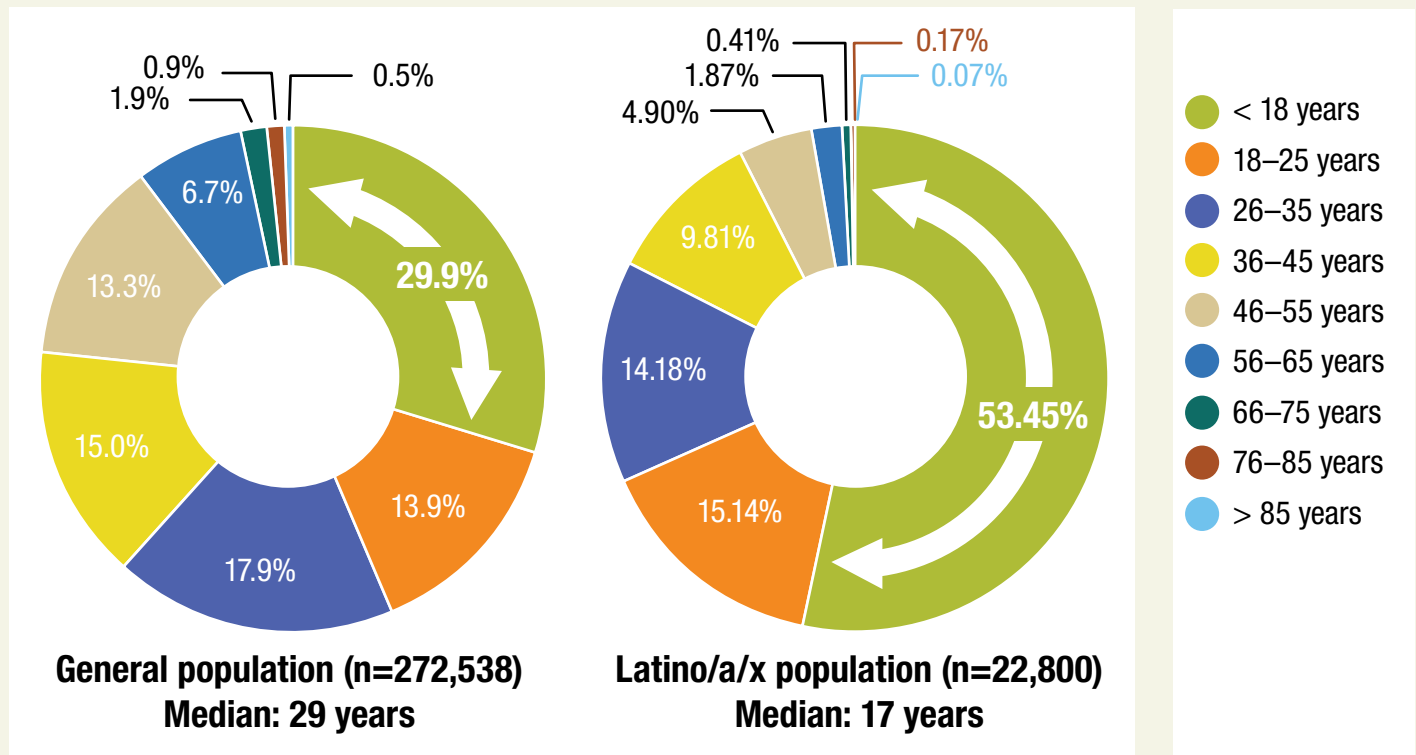


Figure 3: Latino/a/x youth access mental health services more than other age groups, and more than the general population



Voelker, 2017. Prepared in spring 2017 as part of an internship for Oregon Advocacy Commissions Office - Commission on Hispanic Affairs — in partnership with Oregon Enterprise Data Analytics by Kimberly Voelker, a graduate intern at OHSU Public Health. For questions about this data set, contact Lead Inter-agency Researcher Aaron C. Cochran at 503-945-5676 or aaron.c.cochran@dhsosha.state.or.us.

- II. Schools are particularly robust access points for Latino/a/x rural youth and their families. Analyses of OHA quantitative data from 1983–2013 find that Oregon’s Latino/a/x youth are far more likely than the general population (53% compared to 30%) to access mental health from K–12 referrals (Voelker, 2017). Qualitative research also found that culturally specific and rural mental health providers who serve the Latino/a/x community believe schools are an effective and promising platform for mental health services for the Latino/a/x community (St. Amour, 2017; Honda, 2019).**

Much of Oregon’s Latino/a/x population is U.S.-born youth; the native Latino/a/x population has grown by 21% since 2000 (Ruffenach, 2016; Hernandez, 2018). One in four students currently enrolled in the Oregon public school system is Latino/a/x (Oregon Department of Education, 2018; Voelker, 2017). School-based mental health care helps improve Latino/a/x youths’ health and well-being statewide because of:

- The Latino/a/x youth population's comfort with schools as access points for mental health and
- Schools' ability to identify areas for mental health support and refer or provide service for students and their multi-generational family members (Voelker, 2017).

III. To achieve greater health equity – a top priority – Oregon's mental health care system must do the following:

- A. Reconceptualize research from being a static means for collecting numbers to a dynamic and evolving tool for transforming a system that is not yet equitable to one that is.

In Figure 4, for the items “parents withdrawing a minor from mental health services,” “noncompliance with the mental health system” and “terminating mental health care without a clinic agreement,” Latino/a/x youth in Oregon have higher rates of termination than the general population (Voelker, 2017). Since these reasons for termination may imply a poor fit, culturally and linguistically, between client and the provider agency, they raise important questions about **data collection metrics** and **provider-client fit**. It is important to note that seemingly small percentage differences are statistically meaningful and reflect significant differences because the sample size for this dataset is large ($n = 272,538$).

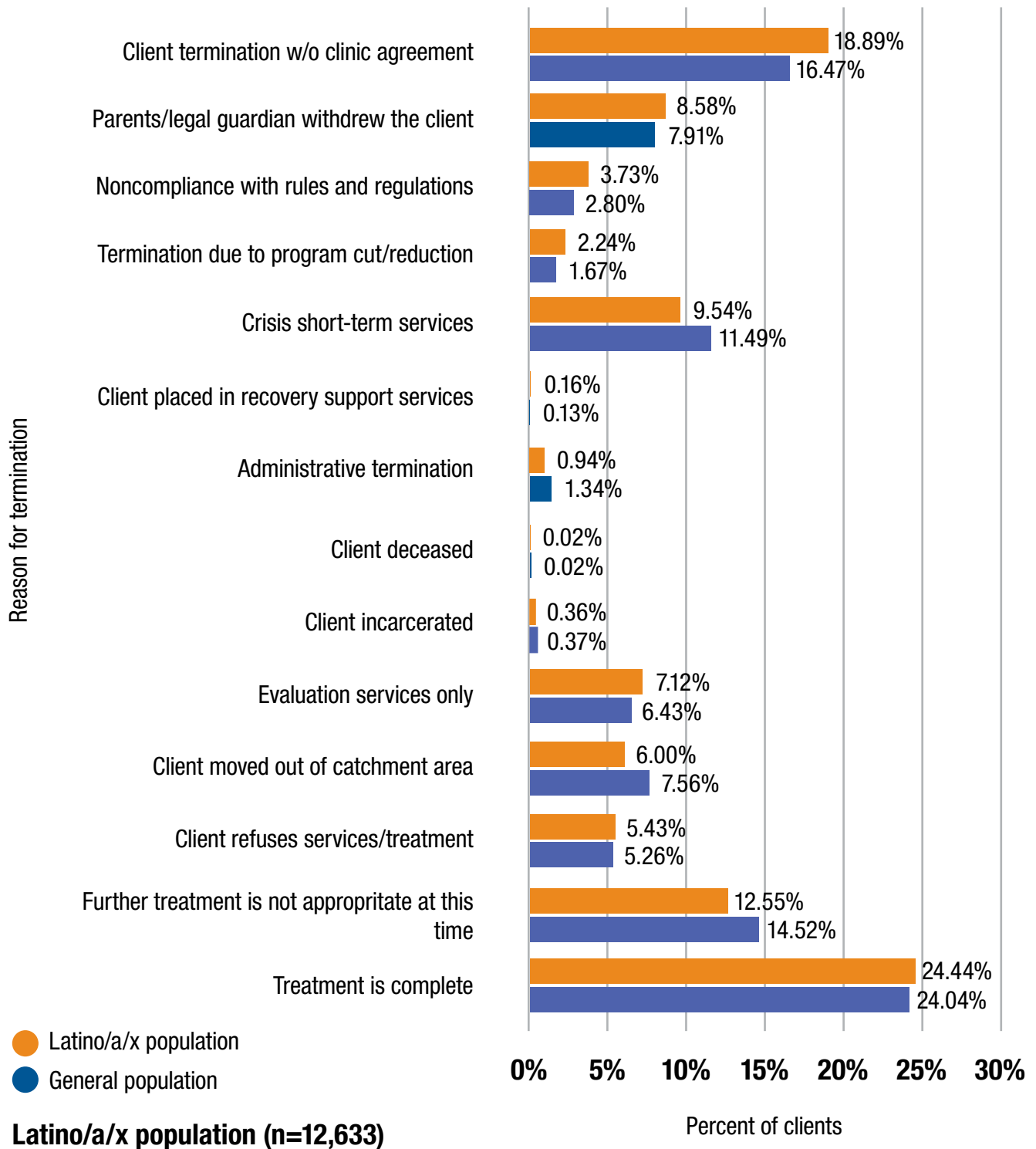
However, these data cannot definitely answer any questions about provider-client fit because they capture only the provider/system perspective. They reflect a collection of “counts” that don't provide deeper information to inform improvements to the mental health system. For example, “Parent/legal guardian withdrew the client,” “Client refuses services/treatment,” “Noncompliance with rules and regulations” and “Client termination without clinic agreement” all reflect termination from a provider perspective. As a result, these data show meaningful differences in termination between Latino/a/x vs. general population clients, but they do not address the question, “**Why** do these differences in termination by ethnic group exist?” or “How can we serve these clients more effectively?”

“Schools are a platform — they reflect where people are going and how we can support their needs. Instead of 10 different ways of funding needs, we focus on creating the platform [in schools] ... and address the needs there ...” (St. Amour, 2017)

— Program Director, Oregon



Figure 4: Differences in provider-described reasons for termination for Latino/a/x individuals vs. the general population point to the need for more culturally specific mental health services





To answer these questions of “why” and “how,” different metrics and data collection, which capture the client perspective and focus on provider-client fit, are necessary. Capturing the client experience of accessing mental health, fit with the provider or other critical aspects of a client continuing with mental health care (including comfort with the provider, communication, setting, treatment approaches and cultural competence, among many possibilities) would speak to why differences exist and point to opportunities for improvement.

At its best, research is a tool for identifying “what is,” as well as “why” and “how.” When used to address all three of these questions iteratively, research becomes an ongoing means for change and, ultimately, transformation. If, for example, the next iteration of data collection regarding mental health includes client-perspective metrics, analyses could answer some questions about why there is a difference between Latino/a/x clients and general population clients. Improvements could be made, more data could be collected and evaluated for the “what” and “why” to evolve into a process of constant improvement and, ultimately, transformation.

In other words, this first study in Oregon analyzing quantitative health data focusing on an underserved group provides a solid starting point for identifying a baseline assessment of mental health for Latinos/as/x in Oregon. It also highlights opportunities for improvement of data collection and application of research. (V. Stewart, personal communication, Oct. 26, 2020).

- B. Vigorous and rigorous evaluations must be a part of all programs and actions related to the implementation of the recommendations herein. Evaluation is to be an essential aspect of implementation planning. Evaluation design, process and content must include input from historically underserved community providers and clients, as well as policy and state agency leaders. Each evaluation of new policies and practices must include both process and outcome assessments that measure efficiency, effort and effectiveness; they will be disseminated to the Oregon Legislature, community providers and policy and state agency leaders.
- C. Increase the mental health care system’s capacity to provide culturally and linguistically specific, trauma-informed care that is deeply embedded with cultural resonance, competence and responsiveness. Accomplish this by building the structures, resources and supports to develop and support effective, skilled bilingual and bicultural providers. Oregon can do this by increasing diversity in and providing training for the workforce, pipeline and credentialing of culturally competent mental and behavioral health providers,



and, by scaling culturally specific mental health provider caseloads to account for the management of cultural complexity* in order to prevent provider burnout and promote equitable provider caseloads.

Even using this provider perspective-only data provided in Figure 4, important differences in Latino/a/x experiences are apparent in:

- Client termination without clinic agreement
- Noncompliance with rules and regulations, and
- Parents or legal guardian withdrew the client.

Given that Latino/a/x youth are particularly receptive to beginning mental health counseling, early termination and noncompliance raise red flags about the goodness-of-fit between providers and clients for Latinos/as/x in Oregon. These concerns were reinforced by findings from qualitative research of mental health practitioners who serve Latino/a/x clients (n=24) and described:

- Lack of cultural- and language-appropriate services as formidable barriers
- Insurance billing systems restrictions preventing the use of culturally specific alternative modalities (including culturally sensitive practices and integrative frameworks[†]), as well as inconsistent and overly complex practices for applying for and receiving insurance coverage for culturally specific services, and
- The current mental health system's focus on principles (independence and individuality) being in direct conflict with Latino/a/x cultural values of interdependence and community (St. Amour, 2017). (For further discussion of this topic, please see page 85.)

Difficulties in communication, misunderstanding of rules and regulations, and inability to build authentic relationship because of language and/or cultural differences all work directly against trust- and relationship-building. These essential elements form the foundation of effective mental health care and imply the exclusion of the critical dimension of cultural competence (Abe-Kim & Takeuchi, 1996). (For further discussion of this topic, please see pg. 115).

* The concept “cultural complexity” is layered and rich; the Oregon Advocacy Commissions hope to do more work to fully articulate this concept. For further discussion on this emerging concept of cultural complexity please see pages 115–117).

† See “Appendix 1, Recommended Modalities and Best Practices in Mental Health & Wellness for Latinos/as/x, on page 173. “Glossary of Terms” section on page 150, and “Known Barriers to Accessing mental health care” section on page 103 for further discussion of culturally specific alternative modalities.



The mental health practitioner workforce, pipeline and credentialing process must be examined and strengthened to increase the number of mental health practitioners with essential training to practice and supervise trauma-informed, linguistically and culturally relevant, culturally specific treatment. Strengthening the mental health provider workforce will help increase access to effective, quality mental health care for all Oregonians.

For current culturally specific mental health providers who are already qualified to provide culturally specific care, it is essential for mental health workplaces to scale the size of caseloads for culturally specific providers. This will help manage **cultural complexity** and account for the necessary financial resources and infrastructure to do so.

Providing culturally specific mental health care requires management of cultural complexity, which requires intensive case management and significant additional time per client for culturally specific providers. Managing cultural complexity requires additional skills, knowledge and labor to:

- Provide extra information and resources on the benefits of mental health care
- Translate and interpret work with the client

“*[There are] no culturally specific services for Latino/a/x, no bilingual providers, and interpreters are often used in a crisis situation and this really doesn't work well and creates barriers*.*”

– Mental Health Provider,
Oregon (St. Amour, 2017)

“*There are very limited resources. In my county there are only two bilingual mental health therapists. If there are others, I don't know where they are.*”

– Mental Health Provider,
Oregon (Honda, 2019)

* This quote reflects the perceptions of a participant in one of the qualitative research studies described in this report. While there are, in fact, culturally specific and bilingual providers in Oregon, they are scarce and not well-distributed throughout the state. This quote therefore highlights the following two truths, critical to this report: there are some culturally specific and bilingual providers in Oregon; and, there are so few providers, in so few places, that there are none in many counties in the state, which would match this provider's perception.

- 
- Provide education and background for mainstream supervisors and workplaces that do not have deep cultural competence
 - Engage in ongoing self-education and development to maintain high standards of cultural competence specific to individual clients, and
 - Take on additional work in consulting and translating or additional cases that clearly call for culturally specific mental health care.

(For further discussion on this emerging concept of cultural complexity please see pages 115–117.)

- D. Establish as standard practice the appointment of practitioners of color and other historically marginalized groups on all licensing boards and the appointment of people of color and other historically marginalized groups on all public bodies.


Thoughtful, deliberate and diverse power-sharing on public bodies will ensure that community needs and considerations for access, structures, resources and supports deeply embedded with cultural resonance, competence and responsiveness are foundational building blocks for public bodies that support all Oregonians.

IV. Community integration is key: Integrating culturally and linguistically specific mental health care with the community services Latinos/as/x in Oregon regularly use will address three prominent barriers for Latinos/as/x — access, retention and stigma.

Community-based organizations and other providers serve Oregonians to address the social determinants of health (SDOH) — the conditions in the environments in which people live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks (Office of Disease Prevention and Health Promotion, 2020). Integration of mental health in the places that Latinos/as/x in Oregon already frequent opens multiple entry points, increases access and enables support for them that “fits.”

“*In my previous job, we had wraparound teams — family members, parish priests, curanderos — and we all aligned with how we were trying to help the family ... we did not shy away from embracing issues and did not label our services as mental health.*”

— Mental Health Provider,
Oregon (St. Amour, 2017)



Integration of services also combats stigma, a prominent barrier to mental health care for Latinos/as/x in Oregon. Providing direct access to mental health care in community centers or health care venues (e.g., clinic, spiritual care) reduces some of the administrative systemic barriers that might foster stigma, fear and disengagement and help make getting mental health care more discreet.

- V. Resource and support developing and maintaining a Latino/a/x mental health task force and a larger culturally specific mental health task force. This Latino/a/x task force will be one of several task forces representing historically underserved groups in Oregon to comprise a larger culturally specific mental health task force.**

This culturally specific mental health task force and the Latino/a/x mental health task force will consider the needs of the state, its underserved communities and the Latino/a/x communities. The task forces' goal will be to eliminate the disparities outlined in OCHA's, OHA's and ODHS's joint research.

These two task forces will be charged with:

- Mapping and coordinating enduring mental health efforts across diverse organizations in Oregon
- Producing and enacting policies
- Developing ongoing collaborations across agencies
- Establishing equitable measurable outcomes and plans for resourcing data collection
- Analyzing data, and
- Overseeing an advisory group regarding mental health centered on equity and historically underserved Oregonians.

“Integrated care works because when folks check in, no one knows why you are there. There is no stigma about mental health. The access is also there since if they go to their primary care doctor they can be referred. It is familiar and they feel welcome.”

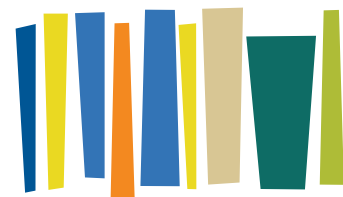
— Mental Health Provider,
Oregon (St. Amour, 2017)



As a public body, this Latino/a/x task force will include a majority of Latinos/as/x in relevant mental health fields, as well as corporate, philanthropic and community-based organizations and the Oregon Advocacy Commissions (the OACs).

Other culturally specific task forces will include majorities of the cultures they represent and also include corporate, philanthropic and community-based organizations and the OACs.

Specific recommendations



What can we do to increase inclusive access?

Specific policy and practice recommendations for increasing access and inclusion in Oregon's mental health system

Access and implementation recommendations came from three work groups comprised of Latino/a/x mental health providers, mental health providers and community members, OHA and ODHS policy administrators, legislators, and OCHA, OHA and ODHS leadership.

This process will be described in greater detail on pages 68 to 71.

Access recommendation 1: Increase systemic resources and implement policy and organizational structures for Latinos/as/x and rural populations to address the scarcity of mental health providers and build support for those providers.

- Build in differential financial incentives for bilingual, bicultural mental health provider recruitment.
- Create a Latino/a/x mental health collaborative across all university systems to prepare future bilingual and bicultural Latino/a/x mental health providers and peer-to-peer counselors. Critical work for this collaborative will be developing and maintaining a Latino/a/x peer mental health specialist certification program.
- In the short term, systematically maximize the roles and use of all mental health providers that fill this lack by applying the designation of “mental health provider” and its associated health care coverage to include:
 - » Qualified mental health associates (QMHAAs), which include unlicensed peer-to-peer counselors and community services
 - » Qualified mental health professionals (QMHPs), which include unlicensed social workers, nurse practitioners of psychology, psychiatrists, psychologists, mental scientists and therapists, and
 - » Licensed interns.
- For the long-term, the Latino/a/x mental health task force will advise strategy to take regarding the “mental health provider” designation and its associated health care coverage. (See Implementation Recommendation #3 below) with engagement of relevant Oregon licensing boards.
- Develop and implement guidelines for foreign provider certification program.



- Increase cultural competency training for supervisors working in Communities of Color and intersectional communities. Doing so will begin to build structures, resources and supports for deeply embedding the mental health system with cultural resonance, competence and responsiveness as well as effective, skilled bilingual and bicultural providers.
- Develop and support culturally competent practitioners working in Communities of Color to become supervisors who will train and mentor new practitioners within a culturally competent framework.
- Create a Latino/a/x mental health shortage designation program in Oregon. This program will be modeled on current federal programs for student loan forgiveness for individuals who work in public service or as teachers (U.S. Department of Education, 2020).
- Seek state and federal funding through the National Institute of Mental Health (NIMH) and other such partners and Latino/a/x media companies to provide culturally competent branding and messaging.
- Create networking opportunities for bicultural and bilingual mental health providers in Oregon by providing resources for an annual conference for the next several years. This allows those in the mental health fields to continue to meet and connect.



Mental health professionals report workload inequities. While caseloads may be similar across mental health professionals, bilingual and bicultural providers are often asked to consult on or provide translation and support to their coworkers for Latino/a/x patients, in addition to their own workloads.

“My supervisor tried to do their best to support [me], but it was hard for them to understand the workload as they were not a person of color.”

— Oregon Provider,
(Honda, 2019)

Access recommendation 2: Data show that schools are a uniquely robust access point for Oregon Latinos/as/x. This calls for increased access to mental health services by building systemic supports for comprehensive care in school districts and schools (Voelker, 2017).

- Ensure service penetration in all counties by increasing investments in school-based health centers (SBHCs). In those counties without SBHCs, provide funding support to federally qualified health centers (FQHCs) for onsite integrated mental health services.

- Ensure that all districts implement trauma-informed culturally specific practices. These practices promote equity, reduce stigma, and foster relationships and student empowerment.

Access recommendation 3: Create dedicated spaces and places for Latino/a/x clients by increasing systemic resources and implementing financial incentives to increase culturally specific mental health programming that combats stigma.

Provide ongoing financial resources to establish a supportive structure to develop culturally specific program models that prioritize cultural resonance, competence and responsiveness. This will help ensure effective mental treatment for Latinos/as/x and developing and retaining skilled bilingual, bicultural providers.

- These culturally specific program models will include modalities [such as including traditional folk healers and *curanderos* (who use spiritual and folk remedies)] and access points (including integrated care centers, community-based care, and integration with spiritual and cultural practices). These models will serve specific areas of mental health care (such as suicide prevention) that match Latinos'/as'/x's conceptions of meaningful mental health care.
- Launch a community media campaign that reduces stigma and normalizes emotional health and well-being. It would address and mitigate the powerful barrier of stigma for Latinos/as/x in Oregon seeking mental health services.



In my previous job, ... We found what worked ... whether it was prayer groups or spiritual practitioners and we were a team. We were also a community event center. It wasn't a place to go if you have a problem. We were trusted and known."


— Provider,
Oregon (St. Amour, 2017)

How do we implement?

Specific recommendations for equitable and inclusive implementation of mental health access recommendations

Implementation recommendation 1: Standardize a new practice of prioritizing appointing equitable representation on public bodies working to improve the mental health system.

- All public bodies related to the mental health system should ensure equitable representation occurs of historically underserved cultural groups. This includes those in fields such as



education, which integrates mental health care at easy access points. Such representation will include community members, experts in the relevant field who identify as part of historically underserved groups, and agency employees who identify with these groups and work in relevant content areas.


A. **Standardize appointing practitioners of color and other historically marginalized groups on all licensing boards and people of color and other historically marginalized groups on all public bodies.**

Thoughtful, deliberate and diverse power-sharing on public bodies will ensure that community needs, considerations for access, structures, resources and supports are foundational building blocks for public bodies that support all Oregonians. This practice deeply embeds these bodies with cultural resonance, competence and responsiveness.

Implementation recommendation 2: Permanently fund and support data collection and analyses that center Latino/a/x and other historically marginalized Oregonians.

- Establish metrics for measuring the outcomes from the client perspective regarding mental health policy changes. These metrics include access, client retention, provider-client demographic matching, provider-client fit or match, and mental health provider workforce retention. Other metrics will be collaboratively developed with equitable representation from individuals who identify with historically underserved cultures. Consideration of “best practice” for these metrics will include cross-cultural definitions and metrics that represent all Oregonians.
- Coordinate efforts across agencies and organizations to collect and analyze culturally specific and equity-informed data. This will be done in appropriately funded and compensated consultation with historically underserved cultural community leaders who have knowledge about their communities’ mental health access.
- Establish service and outreach metrics for coordinated care organizations (CCOs) that provide financial incentives for mental health services to immigrant and refugee, non-English speaking, and historically underserved Oregonians.
- Require CCOs to contract with culturally specific mental health providers, school-based health centers (SBHCs) and federally qualified health centers (FQHCs) for outreach, education and other related mental health services if equitable service metrics are not being met.

Implementation recommendation 3: Resource and support developing and maintaining a Latino/a/x mental health task force and a larger culturally specific mental health task force. This Latino/a/x task force will be one of several task forces representing historically



underserved groups in Oregon to comprise the larger culturally specific mental health task force.

- This culturally specific mental health task force and the Latino/a/x mental health task force will consider the needs of the state and its underserved communities including the Latino/a/x communities. These two task forces' goal will be to eliminate the mental health disparities outlines in OCHA's, OHA's and ODHS's joint research. The task forces will be charged with mapping and coordinating existing mental health efforts across diverse organizations in Oregon, producing and enacting policies, developing ongoing collaborations across agencies, establishing equitable measurable outcomes and plans for resourcing the collection and analysis of data, and overseeing an advisory group regarding mental health centered on equity and historically underserved Oregonians. As a public body, this Latino/a/x task force will include a majority of Latinos/as/x in relevant mental and behavioral health fields, as well as corporate, philanthropic and community-based organizations and the Oregon Advocacy Commissions.
- Majority of culturally specific task forces must be members of the cultures they represent and have similar representation to the Latino/a/x task force.

Implementation recommendation 4: Increase funding for Latino/a/x and other historically underserved mental health services in Oregon, with specific targeted resource allocations for funding increases that ensure equity.

The Latino/a/x mental health task force and the culturally specific mental health task force will inform these resource developments and increases. The groups will also advise its mapping of existing mental health efforts (described in Implementation Recommendation 3).

Crisis de Nuestro Bienestar*: Crisis of Our Emotional Well-being

A Report on Latino[†] Mental Health in Oregon



Hernandez, Hector. (2009). Miraflores Life [autumn]. [Glass and porcelain mosaic on wall]. Portland, OR. Reprinted with permission.

* Crisis of Our Emotional Well-being

[†] The term “Latino/a/x” is used in this report because it both conveys respect for the ongoing transformation of community identity, and also includes the whole spectrum of community, including country of origin or ancestry, generation, gender and gender fluidity. Currently, neither of the alternate terms “Latinx” nor “Hispanic” meets this work’s commitment to inclusivity. (“Hispanic” is a generic term for the Latino/a/x community, used by the U.S. Census Bureau to count only Latinos/as/x with Latin American origin or ancestry, and who are Spanish speakers; it thus does not capture the diversity of the Latino/a/x community).



This report on mental health and Latinos/as/x in Oregon addresses the following four goals:

- To provide data and research, sponsored in partnership by the Oregon Advocacy Commissions (the OACs), Oregon Health Authority (OHA) and Oregon Department of Human Services (ODHS) that documents 30 years of granular administrative data for mental health and Latino/a/x. This research is the basis of the first seminal report of a culturally specific population within the larger context of Oregon's behavioral health system grounded in user data.
- To use an equity lens to integrate decades-old challenges in the current system regarding effective mental health care for Oregon's Latino/a/x communities. Data analyses and analytics of upstream best practices that affect downstream disparities serve as the basis for future systems improvements.
- To make specific recommendations grounded in community-based applied policy research. These recommendations range from policy and practice to systems change, for improving mental health care for Oregon's Latino/a/x communities.
- To share best practices grounded in the belief that effective equitable solutions come from equitable processes. These processes center the individuals and communities most affected, embedding community and stakeholder voice in policy and systems change.

Essential context for reading this report, regarding systemic structural barriers

This study does not examine the structural barriers that impede access to mental health and foster mental health issues for all families and individuals and, disproportionately, for historically marginalized groups. However, we must acknowledge that these structural barriers have set the stage for the challenges addressed in this report. Presented here as a model for community-based applied policy research, this report provides clear and specific recommendations for culturally relevant care, and best policies and practices to improve mental health; it also suggests changes that affect both individuals' everyday lives and longer-term system functioning that will help achieve health and equity for all Oregonians.

Why focus on mental health and not behavioral health?

In Oregon, *Crisis de Nuestro Bienestar* is the first report of its kind to focus specifically on Latino/a/x mental health. While the language du jour in health promotion uses "behavioral health," this report



focuses solely on mental health. The term “behavioral health” is used throughout this report only in instances that refer to the behavioral health system, or to specify that both behavioral and mental health care are relevant. While the terms “mental health” and “behavioral health” are often used interchangeably, there are subtle differences between the two definitions.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as the promotion of habits that affect one’s overall physical health, mental health, resilience and well-being. For example, some maladaptive behaviors that fit into the definition of behavioral health include substance abuse, gambling, smoking, lack of exercise, eating disorders and sex addictions. While behavior health changes center on the individual, they do not address or consider other external factors in a person’s life, such as poverty, discrimination, trauma or other root causes of mental health issues. In contrast, a mental health perspective focuses less on behaviors and more on conditions such as depression, anxiety, post-traumatic stress disorder, toxic stress and, potentially, other severe mental health conditions that brain chemistry or genetic inheritance may cause, as well as environmental or external factors that create imperfect conditions. As we have learned, behavioral health disorders can co-occur with mental health conditions.

Ideally, coordination in these two arenas supports increased and culturally responsive prevention, access to services, accurate diagnosis or evaluation, treatment, recovery, and wellness services to reduce and eliminate mental health disparities throughout the lifespan. While the Latino/a/x community may have many underlying or external challenges, the current systems do not allocate sufficient or targeted resources to deliver the best culturally specific and promising practices to that community.

This report specifically examines the systems and resource allocations that create barriers to equitable development of and access to culturally and linguistically responsive services that support the Latino/a/x community to realize its own potential, cope with distinct stressors, continue to work fruitfully and fully contribute to the community. It is fitting that this report focuses on the mental health data, resources, systemic barriers and practices that create and petrify disparities that affect our community deeply and, therein, provide the unique and timely content and recommendations in this report.

Understanding terminology

This report ends with a glossary of terms. It helps readers understand the meaning of widely used, sometimes complex terms essential to the report’s meaning.



Forewords



Hernandez, William. (n. d.). *The Special Translator*. [Acrylic on canvas]. Reprinted with permission.

Forewords



Irma Linda Castillo, MS

Chair, Oregon Commission on Hispanic Affairs



It is with great pride we share *Crisis de Nuestro Bienestar*, a report on the urgent mental health crisis for Latinos/as/x in Oregon. Oregon is home to roughly 565,177 Latino/a/x residents. In Oregon, those who receive health care coverage under the Oregon Health Plan (Medicaid) are served by coordinating care organizations (CCOs) that combine all types of health care providers (physical health, behavioral health, mental health and dental care) to work together in their local communities. As of 2020, there are 15 CCOs statewide. Thirteen of them operate in the urbanized west side of the state. The 14th is in Central

Oregon, and the 15th is an eastern region CCO that serves 13 rural and pioneer counties. Despite this array of CCOs, Latinos/as/x report challenges in accessing care or receiving information about care available to them. Given the barriers in accessing mental health services, Latino/a/x providers and/or culturally resonant programs and the Oregon Commission on Hispanic Affairs embarked on a two and one-half-year research and analysis period to develop policy-informed recommendations based on research, engagement of a Latino/a/x community advisory committee, and consultation with department directors and lead partners in the Oregon Health Authority (OHA) and the Oregon Department of Human Services (ODHS). During this period, our research interns delved deeply into 30 years of previously unreviewed mental health data from the Oregon Health Authority. In the data we found interesting trends and opportunities for policy recommendations, system improvements and implementation strategies.

For decades, our mental health community and Oregon residents have decried the dearth of mental health funding, resources and sufficient culturally and linguistically responsive practitioners, programs and providers. The needed changes run the gamut between practicing and providing behavioral health, specifically mental health, addictions treatment and emotional wellness care. Our community requires care that honors our identity, values, culture, language and view of health. Latinos/as/x need to be able to access these services in community venues and with discretion, albeit in the home or the school-based health clinic, community center, nonprofit or local primary care clinic. Our community struggles with the stigma of experiencing mental health urgencies and seeking care. The increasing level of toxic stress, trauma, PTSD, depression, generalized anxiety, suicidal youth and other culture bound concerns continues to highlight the vulnerabilities and inequities in our health care, access to insurance and a provider system that can effectively meet the mental health needs of Latinos/as/x.



In Oregon, the largest represented Latino/a/x group is Mexican American. Latinos/as/x come from 20 different countries but share a common ancestry of the Spanish language. And even with language as a common identifier, there are many countries and regions for whom their first language is an indigenous dialect. Given this diversity, self-identification is important as we have a long history of migration into the Americas and the Caribbean, evident in our Spanish, German, Italian or Asian surnames. We make up a complex *mélange* of indigenous, European, Asian and African roots. We are multi-racial, -lingual and multi-cultural. Even today, our identity continues to evolve as we acknowledge our gendered language and make way for gender fluidity via the term “Latinx.” Religion and spirituality play a significant role in our lives whether in indigenous or ancestral roots mixed with parts of the religion of colonizers. While 65% of Latinos/as/x are Catholic (Pew Center Research, 2019), these beliefs and those of other denominations play a significant part in our daily spiritual lives, indigenous beliefs and practices due to our history of colonization and attempts to retain indigenous spirituality, culture, language and migration patterns. These beliefs and cultural practices continue to live on through our African, European and/or Asian roots.

Our families and ancestors play a significant role in our lives and many individuals live in large multigenerational, mixed status homes that can also include immediate and extended family. Our elders are the carriers of ancestral history, health practices, culture and language. Key core values include *familismo*, placing the needs of family above the individual, and collectivism, the preference to belong and work in group or community. Most families are tightly knit and rely upon one another. Respect is another important cultural value. We see it in the way we place great social worth and ultimate decision-making power on authority figures such as our parents, teachers, elders and doctors. At times because of this respect for authority status, we avoid disagreeing, expressing negative feelings or expressing doubts in their presence. As such, we may withhold information, not follow recommendations or terminate ongoing care or medications. If trust, transparency, *personalismo* (emotional resonance and personal involvement), acceptance, collaborative care and openness are provided, the communication and relationship with service providers can be improved and, thus, mental health care for the individual and/or family can improve.

We have a world view that conceptualizes health as synergistic. Its expression is within the continuum of body, mind, emotion and spirit. In metaphor and in practice, the use of the medicine wheel is often referred to or used in healing work. In this regard, medicine denotes a practical, sacred and spiritual significance. Even in urban and rural communities, we have an extensive practice of using *curanderos*, folk healers, herbalists and a myriad of other traditional healers and treatments. We have a belief in natural phenomena and the supernatural. It is not uncommon for Latinos/as/x to believe they have been hexed or given “*mal de ojo*” or the evil eye, which then caused one to feel unwell. Sometimes physical and mental health ailments may be seen as a

result of a greater spiritual problem. Equally, depending on the level of acculturation or biculturalism, members may value counseling from counselors, psychologists and may even have a practice of seeing a psychiatrist for psychoanalysis. The continuum of mental health use is broad and varied. Even urban pharmacists may use a mixture of traditional herbology, modern treatments and medications. For Latinos/as/x, any successful treatment for health or illness must consider the whole person's culture, language, beliefs and values.



With this cultural context, community advice, and the research included in this report, we offer key policy recommendations in access and implementation to improve mental health services to our community. Implementing improved and equitable care for Latinos/as/x will be a multi-layered process and require investment of time, funding and system collaboration to build sustainable health care equity in the state. Through this report and process, practice and resource improvements, we look forward to effectively addressing gaps in the system to uplift and fortify the continued mental health, well-being and resilience of our Latino/a/x community.



Steve Allen, Behavioral Health Director Oregon Health Authority



Everyone in Oregon deserves simple access to mental illness and addictions services and supports that are responsive to their unique characteristics and conditions and lead to meaningful improvements in their lives. The reality, however, is we remain far from this goal. Oregon's behavioral health systems are not meeting our needs. These failures come at devastating human and financial cost. Their impacts are even worse for our Communities of Color because they experience an even deeper chasm between what they need and what there is. The color of your skin, your culture, where you live and the language you speak all affect health care access, use and the quality of care you receive.

Despite the harsh realities of health inequities experienced by children and families within our Communities of Color, too often these disparities have remained hidden and unaddressed within health policies for lack of data that breaks out use and outcomes by race. The authors of this report have brought together fresh data sets, analyses and insights that shed light on the reality of important health disparities affecting our Latino/a/x communities. The data presented here also highlight disparities across all our Communities of Color. The data provide an incredibly valuable resource as the Oregon Health Authority begins work in earnest to resolve health disparities leading with race as a priority in Oregon within the next decade.

We congratulate the authors and all those who contributed to this important work on their accomplishments and look forward to the partnerships and ongoing work ahead to achieve our goal of health equity for all.



Fariborz Pakseresht, Director Oregon Department of Human Services



This research on mental health disparities for Latinos/as/x in Oregon sheds light on this under-reported issue. The study shows how and why individuals are accessing mental health services. We need to know this information before we can begin addressing this disparity and help Latinos/as/x in Oregon with their mental health needs. For too long there has been confusing or insufficient research about Latinos/as/x and mental health.

The Oregon Department of Human Services' mission is to help Oregonians in their own communities achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity. This mission is for all Oregonians. We offer our steadfast commitment toward mental health equity for Oregon's Latino/a/x community and improving the behavioral health system so Latinos/as/x have equitable representation and service equity.

The report also highlights the importance of providing and using mental health services earlier in life, particularly because nearly one-quarter of the Oregon population ages 0–18 is Latino/a/x. It is equally important to measure and quantify the effectiveness of these services to inform needed improvements and adjustments. Positive youth development contributes to children and youth well-being and helps divert youth from involvement in juvenile and, ultimately, adult justice systems.

With the excellent information in this report, we can now focus on evidence-based best practices grounded in culturally appropriate services through bilingual and bicultural providers to Oregon's Latino/a/x population, more than half a million strong.

We in the Oregon Department of Human Services recognize that successful implementation of the recommendations in this report requires partnerships across systems and agencies. It is only together we can fulfill our promise of service equity in mental and behavioral health to Oregon's Latino/a/x population.

It is an honor to have been a part of this work. I applaud the Oregon Commission on Hispanic Affairs for accomplishing this very needed report.

Alberto Moreno, MSW

Chair Emeritus, Oregon Commission on Hispanic Affairs



During my tenure as chair for the Commission on Hispanic Affairs, I had the pleasure of traveling the state and meeting with many of Oregon's Latino/a/x communities. As I travelled from Portland to the Mid-Columbia Valley to Eastern Oregon, Central Oregon, Southern Oregon, the Coast and the Willamette Valley, I got to hear about the vibrancy and resiliency of the Latino/a/x community that is now half a million strong.

We also got to hear about some of the unmet needs. And, always, we heard that the top unmet need for this community is mental health.

At this time in our history, our families are experiencing tremendous stress loads. As a result, our families and our children are experiencing a great deal of trauma. Many of our children, for example, are reporting PTSD-like symptoms. This — coupled with geographic, linguistic and familial isolation and a dearth of Latino/a/x mental health providers — threatens to create the perfect mental health storm for our community.

For this reason, this august commission decided to compile and publish this first ever Crisis de Nuestro Bienestar report. It is not meant to be static but to be a living report that not only articulates the found disparities but also lays out a policy framework to meaningfully redress these structural and systemic inequities.

Add to this some of the findings of our report, which include:

- A limited number of qualified bilingual, bicultural providers
- Low insurance rates
- A generalized stigma associated with seeking out mental health services
- Dominant system models of care that do not meet our needs
- Perverse structural incentives within the CCO system that financially reward organizations that provide mental health care for white-led and mainstream service organizations, rather than culturally and linguistically specific services, and
- Inadequate funding for culturally competent, trauma-informed mental health services.



As evidenced by this report, there are many opportunities to strengthen mental health services for the Latino/a/x community. We will ensure this community has access to the mental health services they need by designing integrated models of care, ensuring we have the necessary pipeline of future culturally specific providers (e.g., peer mental health specialists), and investing in mental health providers who serve Latinos/as/x.

We hope that this seminal report will serve service providers and state policy makers by suggesting a more culturally responsive mental health system of care for Latino/a/x individuals in Oregon. We want to thank you and our partners at OHA and ODHS for working with us to bring this to you.

Acknowledgments



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Thank you to ODHS and OHA for contributing report design, formatting and Spanish translation.

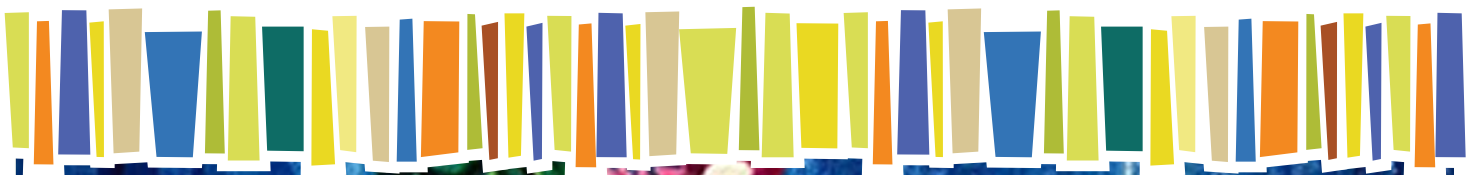
OCHA is honored to have the artwork of these artists in this report (see their biographies on pages 179–181).

Tamara Adams
Daniel DeSiga
Hector Hernandez
William Hernandez
Liliflor Art (Lilia Ramirez)
Henry Ramos

Special thanks and deep appreciation to Lucy Baker, administrator of the Oregon Advocacy Commissions Office, for her unflagging support of this seminal report. This report is the fruit of many years of labor, sparked by Lucy's vision, passion, caring and respect. It amplifies the thoughts and longstanding concerns of the OCHA commissioners, creates the space, dedicates the capacity, and believes in and honors the power of respectful collaboration, experience, expertise and knowledge from diverse perspectives.



Symbolism of artwork





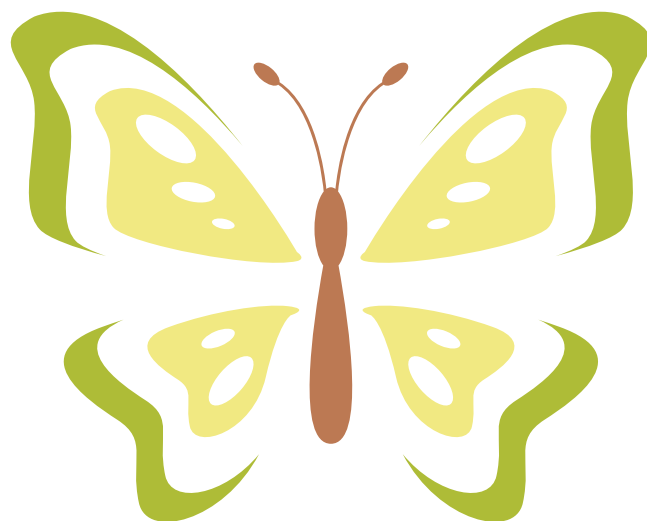
Symbolism of artwork in *Crisis de Nuestro Bienestar*

Symbology, mythology represented
throughout this report

Butterfly

As a symbol, the butterfly carries
many meanings.

- Immigrant rights activists have seen the butterfly as a symbol of fluid and peaceful migration for generations. The monarch butterfly represents the dignity and resilience of migrants, and all living beings' right to move freely.
- The first monarchs traditionally reach their winter home in Mexico by the first of November. People connect the monarchs' arrival with two events that occur at the time:
 - » Corn harvest: People in the region have noticed the arrival of monarchs since pre-Hispanic times. In the language of the native Purépecha Indians, the monarch butterfly is known as the harvester butterfly, because monarchs appear when it's time to harvest the corn.
 - » Day of the Dead: The Mexican holiday Día de los Muertos also occurs when the monarchs arrive. According to traditional belief, the monarchs are the souls of ancestors who are returning to Earth for their annual visit. Festivals and parades honor this wonderful event.
- Born out of the caterpillar in the chrysalis, butterflies were a symbol of rebirth, regeneration, happiness and joy to Native Americans in Mexico; some tribes considered butterflies a symbol of the earth's fertility.
- The Meso-Americans have deeply incorporated the butterfly in their myths. In Aztec and Mayan mythology, the god of fire, Xiutecutli, is represented as a butterfly. Fire, like the butterfly, is a symbol of transformation. The Goddess Iztapalotl, the Obsidian Butterfly, stands for purification and rejuvenation by sacrifice. The powerful plumed serpent god Quetzalcoatl is described as initially descending to earth as a chrysalis, then painfully emerging into full light as a beautiful butterfly and a symbol of perfection. In Central America, butterflies are a sign of love. They will bring love to the person who spots them.





Hummingbird

Hummingbirds are seen as healers and bringers of love, good luck and joy.

Hummingbirds have a long history of folklore and symbolism in native cultures.

The Aztecs saw them as messengers between them and their ancestors or the gods. Mexican elders say Huitzilopochtli guided the Aztecs' long migration to the Valley of Mexico.

The Inca used hummingbird feathers in their fine garments, ritual sacrifices and even architecture. The hummingbird is thus the symbol of strength in life's struggle to elevate consciousness — to follow your dreams.

The hummingbird generally symbolizes joy and playfulness, as well as adaptability.



Sunflower

Not many people are aware that the beautiful common sunflower (*Helianthus annuus*) — the state flower of Kansas — is native to Mexico (and was probably domesticated there as far back as 2600 BCE). Even fewer will be aware that the sunflower was a symbol and metaphor of war for the Mexica (Aztecs) — a key offering to the war god, Huitzilopochtli. It was depicted on the shields of several important deities (Mursell, n.d.).

Known in Spanish as girasol or mirasol, the sunflower has long been used in Mexico. It and so many other indigenous plants are used as ornamental flowers, as a food source (the seeds can be eaten fresh or ground up and mixed into the traditional thin porridge-like beverage known as *atole*), as medicine and as a sacred symbol.



Pic 1: Pre-Hispanic sunflower motifs: ceramic spindle whorls from Xaltocan (top); stamp from Azcapotzalco (bottom left); Mexican stone sculpture (bottom right).



Art selection process

Members of the Oregon Commission on Hispanic Affairs (OCHA) circulated messages through social media and personal contacts soliciting Latino/a/x artwork to the Oregon Advocacy Commissions Office (the OACO). Several artists submitted works. A subcommittee of OCHA commissioners reviewed the submissions and selected representative art works. The one non-Latino/a/x artist included was Tamara Adams, widely recognized as an ally to the Northwest Latino/a/x community. All other artists are Latino/a/x from the Northwest and California. We are so grateful to our talented community.

Index of artwork

In order of appearance:

"Flight of the Butterflies"	Liliflor Art (Lilia Ramirez)
"Monarca Sunrise"	Hector Hernandez
"Miraflores Life Autumn"	Hector Hernandez
"The Special Translator"	William Hernandez
"Corazon de Colibri (Hummingbird Heart)"	Liliflor Art (Lilia Ramirez)
"Gazing Deer under the Moon"	Henry Ramos
"Juntos Podemos"	Liliflor Art (Lilia Ramirez)
"Connection of Love"	William Hernandez
"El Retorno del Chasqui"	William Hernandez
"The Bridge of Love"	William Hernandez
"Keep the Light in the House Low"	William Hernandez
"The Most Beautiful Poem for You"	William Hernandez
"Wish for Our Daughters"	Tamara Adams
"Our Lady of Guadalupe"	Tamara Adams
Mural for "El Dia de los Muertos/Altar para Diego Rivera"	William Hernandez
"Dreaming of Educational Horizons"	Hector Hernandez
Woman farmworker in a field	Daniel DeSiga
"El Serape"	Daniel DeSiga
"Revival of Hope and Wellness"	Hector Hernandez
"Colegio Cesar Chavez"	Daniel DeSiga
"My Birthday Dream"	William Hernandez



“Unity and achievement”

Farmworkers working in a field on an open book

“El Beso”

“Frida’s metamorphosis”

“Tree Spirit”

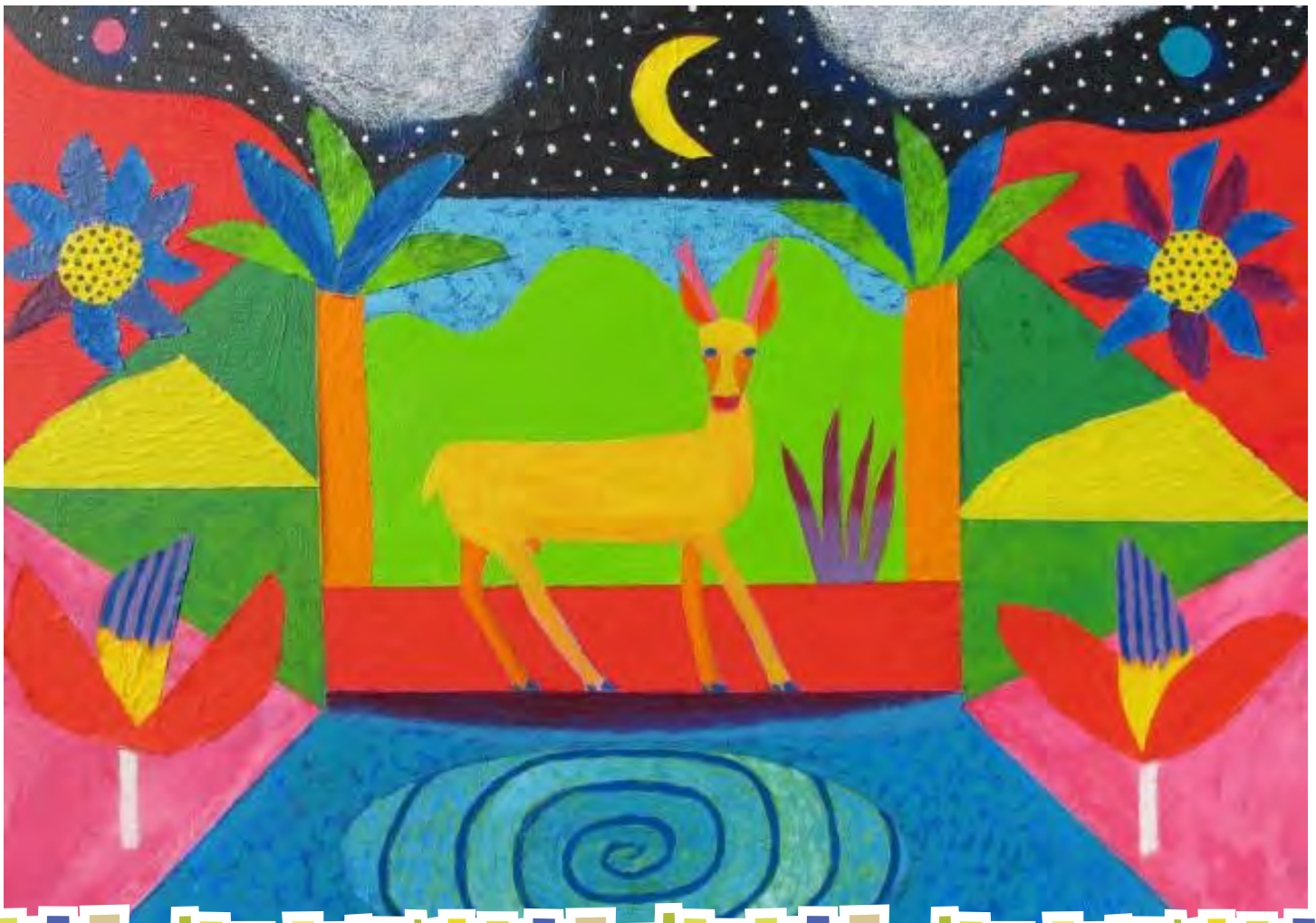
Hector Hernandez

Daniel DeSiga

Liliflor Art (Lilia Ramirez)

Hector Hernandez

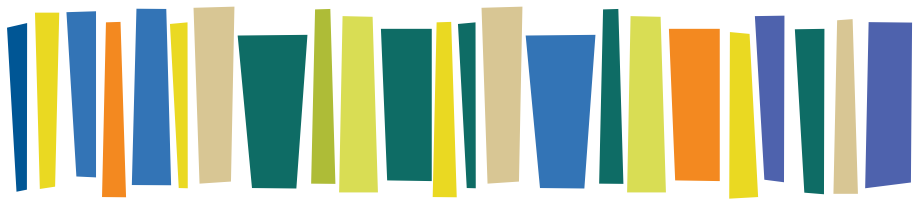
Tamara Adams



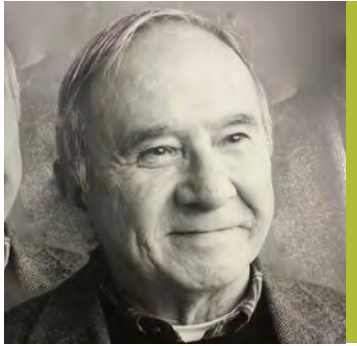
Perspective from 2020



Ramos, Henry. (2017). *Gazing Deer under the Moon*. [Acrylics and collage on canvas]. Reprinted with permission.



Perspective from 2020: the year of COVID-19, Black Lives Matter, immigration and wildfires, and their impact on Latino/a/x communities



Joseph Gallegos, PhD, OCHA Commissioner,
former State Representative

This report strongly acknowledges four events in 2020 that have and will have significant effect upon the Latino/a/x communities and the (mental) health of individuals and families for years to come. The novel COVID-19 virus, immigration policies, the Black Lives Matter movement and Oregon wildfires all have significant implications for Latinos/as/x. The Oregon Legislature saw fit to extend emergency funding to undocumented workers.

The incidence of COVID-19 virus cases and deaths have occurred at disproportionate rates among Latinos/as/x nationally and in Oregon. Latinos/as/x are essential workers, such as grocery clerks or food service workers, who also have low socioeconomic status. Often hard-pressed to make ends meet, these individuals frequently have to seek work where social distancing is a challenge.

The Black Lives Matter movement followed the death of several Black individuals at the hands of police and ignited protests around the world against police brutality. As BIPOC (Black, Indigenous, People of Color), Latinos/as/x are participating in the movement and seeking justice for grievances



Poem by Sonya Renee Taylor



such as those in the Black community. Like Blacks, Latinos/as/x are overrepresented in the Oregon prison and criminal justice systems. They also have suffered deaths and injuries at the hands of local and state police. The Oregon Legislature in 2013 passed a package of laws seeking to reform the state justice system. Subsequent legislative sessions have continued with the progression of similar reform laws. In 2020, Governor Brown called a special session to develop and pass laws that specifically respond to calls to defund the police. An example of defunding the police would be withdrawing resource officers from public schools and replacing them with mental health providers. A similar effort would put more mental and behavioral health workers in ongoing partnerships with police.

Recent immigration policies by the federal government have intensely traumatized Latino/a/x communities and families and may have visited the most cruel and traumatic experiences on this community. In 2020, children remain incarcerated in border holding centers. In June, a federal judge ruled that, for fear of COVID-19, the children must be immediately released. By late 2020, the rule has yet to be fully implemented. In fact, national media have reported that the federal government cannot locate parents of nearly 500 children. This unjust and possibly illegal detainment will leave lasting psychological scars on the children and their families. It brings together the virus and justice catastrophes of 2020. The fear of deportation and imprisonment adds to the mental stress experienced by the community. Oregon and several Oregon cities are designated as sanctuary jurisdictions in which local law enforcement choose not to cooperate with ICE officers.

In the midst of unbelievable chaos, here is an invincible hope for the future. The stay-at-home directive has given time to reflect. Streets are quieter, the birds and animals bask in the new solitude, the air is cleaner, and people find they

“ *Peace making doesn't mean passivity. It is the act of interrupting injustice without mirroring injustice, the act of disarming evil without destroying the evildoer, the act of finding a third way that is neither fight nor flight but the careful, arduous pursuit of reconciliation and justice. It is about a revolution of love that is big enough to set both the oppressed and the oppressors free.*”

— Shane Claiborne,
Common Prayer: A Liturgy for Ordinary
Radicals

“ *In the midst of winter, I found within me an invincible summer.*”

— Albert Camus

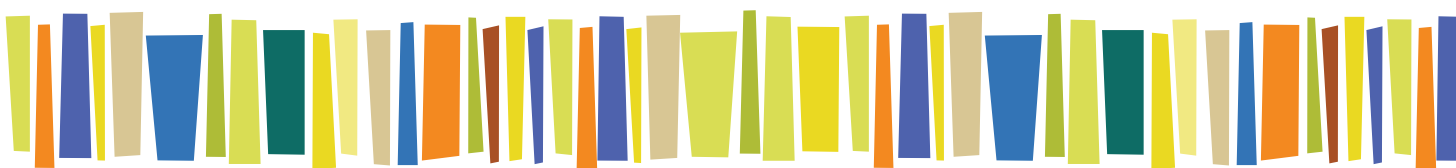


can live on fewer essentials. 2020 provides an opportunity to take stock, and to consider what is truly important.

In the midst of the pandemic that has allowed everyone to step back, society has hit a pause button, providing an opportunity to define what the restart looks like. Can the restart be based not on consumerism but on meeting essential needs such as health care for all, or a minimum income for all? Can it address the income gap in a way that protects our most vulnerable communities without judgement of worth and saves the planet as well? Can it assure food security for all? This is the challenge. It will not be easy to meet this challenge, but this report provides guidance to change the very values of a society — compassion instead of greed, hope instead of fear and love instead of hate. These are the conditions under which the mental health of the Latino/a/x communities and the community at large will flourish.

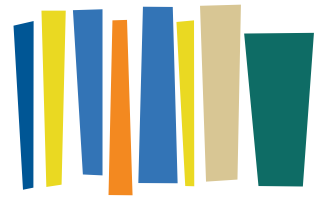


Building a bridge between community and legislative policy: OCHA and the OACs

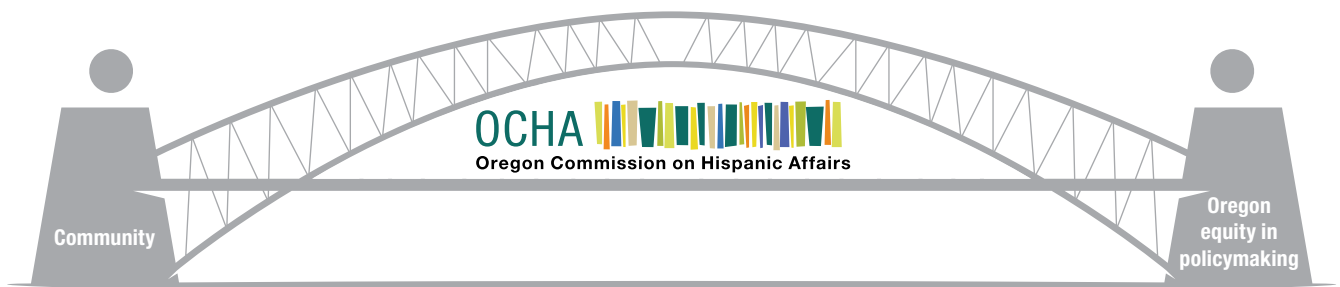


Liliflor Art (Ramirez, Lilia). (2019). Juntos Podemos. [Acrylic on wall]. Lock Prep Academy (Cesar Chavez Community Day Mural) City of Los Angeles, CA. Reprinted with permission.

Building a bridge between community and legislative policy: OCHA and the OACs



This section introduces the reader to the Oregon Commission on Hispanic Affairs (OCHA) and the Oregon Advocacy Commissions (OACs), their missions and their best practices. These organizations bring concerns, generated from the community, to affect legislative change. The section describes research related to policy making and the legislative process in a way that should provide for replicability by other public or nonprofit advocacy groups.




Who are the OCHA and the OACs?

Who is the OCHA?

The mission of the Oregon Commission on Hispanic Affairs (OCHA) is to work toward economic, social, political and legal equality for Oregon's Latino/a/x population. The OCHA's vision is to serve the people of Oregon to empower and support Latinos/as/x through its role as a policy advisor to Oregon state policy makers and leaders. The OCHA is a catalyst that empowers partnerships between state government and Latino/a/x communities in rural and urban areas. This ensures success for all Latinos/as/x by addressing issues at the policy level.

The OCHA works toward its mission and vision by working collaboratively to raise awareness and address challenges facing Latinos/as/x across the state. It researches issues, informs discussions and provides advice for state policy makers, including the Governor, legislators and departmental leaders, on improving the success of Latinos/as/x and Latino/a/x communities throughout Oregon.

The OCHA also promotes leadership of Latinos/as/x in state decision-making around issues that affect Latino/a/x lives and success by recommending Latino/a/x leaders to the Governor for



appointments to boards and commissions, and to the Legislature for participation on taskforces and work groups. Each legislative session, OCHA commissioners go to the Capitol to work with our community partners and legislators to support equitable policymaking in OCHA's seven priority areas, testifying in support of bills that level the playing field for success and tracking these bills through the legislative process.

The OCHA is composed of nine distinguished community members appointed by the Governor and confirmed by the Senate. The OCHA also includes two legislators appointed by the president of the Senate and the speaker of the House. See OCHA member bios: <https://www.oregon.gov/oac/ocha/Pages/index.aspx>.

2020 OCHA Commission members

Irma Linda Castillo, MS, Chair
Daniel López-Cevallos, PhD, MPH, Past Vice Chair
Gustavo Morales, Vice Chair
Jonathan Chavez Baez, MA
Ashley Espinoza Valdez
Joseph Gallegos, PhD
Josefina Riggs
Marisa Salinas
Alberto Moreno, MSW, Chair Emeritus
Rep. Andrea Salinas

OCHA commissioners



Irma Linda Castillo, MS
Chair



Gustavo Morales
Vice Chair



Rep. Andrea Salinas



Jonathan Chavez-Baez, MA
Commissioner



Ashley Espinoza Valdez
Commissioner



Joseph Gallegos, PhD
Commissioner



Daniel López-Cevallos,
PhD, MPH
Commissioner



Alberto Moreno, Chair
Emeritus, Oregon
Commission on Hispanic
Affairs



Josefina Riggs
Commissioner



Marisa Salinas
Commissioner

OCHA's sister commissions: The Oregon Advocacy Commissions (OACs) and the Oregon Advocacy Commissions Office

The Oregon Advocacy Commissions (OACs) statutorily bring the voice and equity lens of underrepresented communities statewide to the policy table. The OACs achieve this by researching issues, informing, providing advice for state policy makers and decision makers on improving the success of all Oregonians and growing diverse leadership into state government. The OACs advise the Governor, legislators and departmental leadership. The OACs regularly work intersectionally and in partnership with each other to amplify voices in equitable policy making.

The four commissions that comprise the OACs include:

1. [Asian and Pacific Islander Affairs \(OCAPIA\)](#)
2. [Black Affairs \(OCBA\)](#)
3. [Hispanic Affairs \(OCHA\)](#)



4. [Oregon Commission for Women \(OCFW\)](#)

The Oregon Advocacy Commissions Office (OACO)

The [Oregon Advocacy Commissions Office](#) supports the statutory charges of the four commissions collectively known as the Oregon Advocacy Commissions (OACs). They are the [Oregon Commission on Asian and Pacific Islander Affairs](#) (OCAPIA), [Oregon Commission on Black Affairs](#) (OCBA), [Oregon Commission on Hispanic Affairs](#) (OCHA), and the [Oregon Commission for Women](#) (OCFW). Each has nine Governor-appointed commissioners and two legislators appointed by the Senate president and speaker of the House and confirmed by the Senate. The OACO focuses its support on the OACs' seven strategic priority areas:

- Education
- Jobs and the economy
- Justice, safety and policing
- Housing and stable families
- Health and health care
- Civic engagement
- Environmental justice

The OACO supports the advocacy commissions' statutory missions and best practices as they identify and study longstanding challenges to Communities of Color and women using:

- Intersectional and rural analysis for all key issues identified by the advocacy commissions
- Work within the policy arc (problem identification, study/research, policy making, resourcing, evaluation) over a course of several cycles to track effectiveness and guide change
- Best practices integration for community-informed, trauma-informed, culturally informed, granular data-informed and equitable policy remedies and programmatic effectiveness, and
- Applied policy research founded on equity and associated upstream analytics.

To accomplish its charge, the OACO works collaboratively with the OACs, the Governor's Office, legislators, and departmental and research partners within government and universities statewide. The OACO maintains a liaison with and growing partnerships with constituent community groups and research partners in state government and Oregon universities. It grows constituent representation in leadership positions in state government and supports the OACs' recommendations to policy makers and the Governor on key issues facing their constituents as well



as providing legislative tracking; coordinating and submitting testimony; and representing the OACs with policy makers and partners, as needed, to inform ongoing policy work and advance the OACs' initiatives.

The OACs' best practices for bridging community to equitable public policy making

The current report centering the experiences of Latinos/as/x in Oregon embodies the principles that drive OCHA'S mission and vision and the OACs' best practices.

These principles include:

- Conducting research in keeping with the OACs' policy arc — research conducted for the purpose of influencing change to systems that do not yet equitably serve underserved communities
- Centering the experience of community members with space for individuals to engage authentically with all of their intersectional identities
- Grounding research in collaboration across communities, state agencies and legislative leaders recommends work for the parties most affected by the research findings and recommendations, and
- Learning from community leaders with a long history of knowledge and experience in this field.



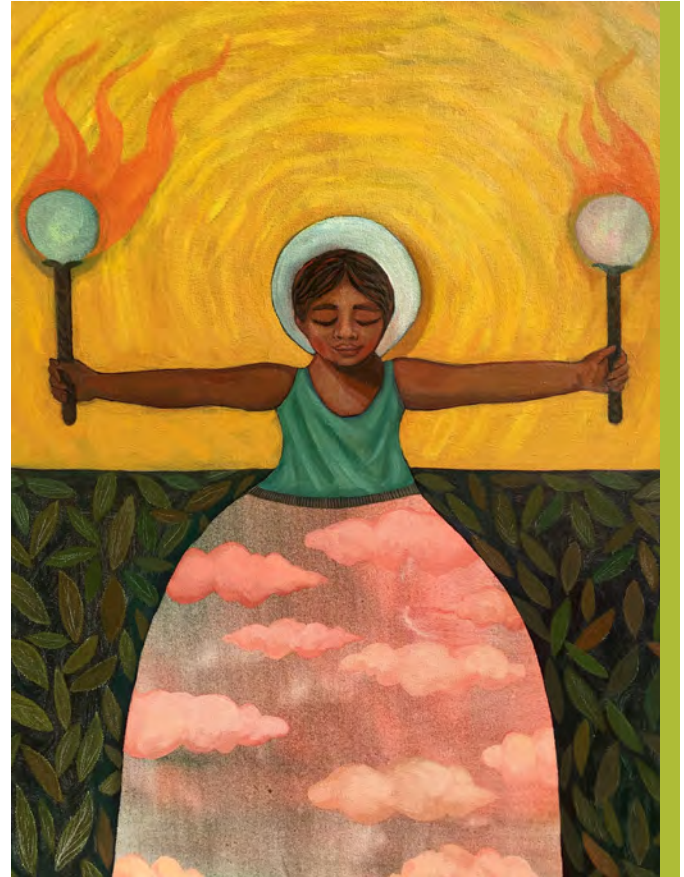
OAC best practice: The Policy Arc

The Policy Arc is a policy process model that details the trajectory from identification and study of a problem, to policy remedies in the form of recommendations, to legislative concept, and to action. The Oregon Advocacy Commissions formally adopted this process in 2017 to reflect their own best practice in policy advising. It provides the OACs with a policy planning and timeline preparation tool to address specific community issues through public policy means over a period of years that may be phased over several legislative sessions, administrative rule cycles, applied policy research, and community and partner engagement.

All policy begins with a concept and hopefully ends with a desired action.

1. The initial conceptualization addresses a need or problem. There are specific stages to the Policy Arc from the initial conceptualization of need or problem to be solved.
2. The second stage is the formation of a plan or strategy to address the need into a proposal.
3. This stage includes approval of the proposal or, in the case of a legislative bill, the passage of a bill and the allocation of resources.
4. The next stage is the implementation of the law into program.
5. Finally comes the evaluation of results and redefinition of the issue, need, or problem.

In partnership with community stakeholders and state partners, the Oregon Commission on Hispanic Affairs (OCHA) has incorporated all aspects of the Policy Arc and Oregon Advocacy Commissions'



Hernandez, William. (2018). Connection of Love. [Acrylic on canvas]. Public Collection at Gladys McCoy Health Department Headquarters. Portland, OR. Reprinted with permission.





(OACs) best practices into the work presented in *Crisis de Nuestro Bienestar*. This report frames and will guide the policy work and outcomes into the future with established policy partnerships. These partnerships also help assure the alignment of the recommendations of the report within larger state efforts around equity and access for marginalized and under-represented populations.

Crisis de Nuestro Bienestar: A Report on Latino Mental Health in Oregon is the first, seminal report on the status of Latino mental health, usage, and policy recommendations in 30 years for Oregon.

As noted earlier, it is the identification of a problem that begins the policy process, and it usually starts with a needs assessment. This step is the foundation from which all other phases of the Policy Arc will unfold. It is also the most political. There will be many perspectives on just what constitutes the problem and just as many about the nature of “the problem.” For that reason, building partnerships to share perspectives, and conducting rigorous mixed-methods (quantitative and qualitative) research is critical to this step. For this work on Latino/a/x mental health in Oregon, this phase of work included approaching the Governor’s Office, the Oregon Health Authority (OHA), and the Oregon Department of Human Services (ODHS) to be partners. Also, in keeping with a social action research (SAR*) approach, it included engaging with culturally specific mental health providers statewide to share their experiences and ideas for improving mental health for Latinos/as/x.

The second step in the Policy Arc is to develop policy proposals based upon the research findings. For this work on Latinos/as/x and mental health, community stakeholders helped analyze findings and develop recommendations. Data gathered by various researchers were pooled and cross-checked to identify themes to which bill proposals could be developed and presented to bicameral and bipartisan legislators in search of legislative sponsors. The concept proposals were generally met favorably by Oregon law makers, because the concepts had such strong supportive data and strong community-based advocates. Nonetheless, each bill associated with the study, whether through its partners or by OCHA, was subjected to the usual process of hearings, bill-working, fiscal review, and House and Senate votes. If the proposed bills passed, they would go to the Governor for her signature. This last act signifies the next step in the Policy Arc, that of authorization.

* Similar to the variable uses of the term “Latino/a/x” in this report, research terms such as social action research (SAR), community-based research (CBPR) and participatory action research (PAR) are used often interchangeably. (For full definitions of each of these terms, please refer to the Glossary, on page 149–150.) These terms refer collectively to a method of inquiry that includes the subjects in all phases of the research. Further, they refer to a type of applied research with the purpose of action; in the case of this report, legislative action aims at bettering mental health services for Oregon’s Latinos/as/x.



Once signed into law, the initiating concept goes through a rules-making process prior to implementation. Implementation is the next crucial step. Here, the initiating concept may be hard to recognize and, again, this is a time for strong community advocacy to ensure as much as possible of the original concept is retained. Much depends on the agency and how the agency administration decides to implement the new regulations.

The final step in the Policy Arc is evaluation, and in this last step, the originating concept (or the problem being addressed) will get redefined as solved, not solved, partially solved, etc.

The Policy Arc may appear to be a linear process, but it is anything but that. As one can see from the final evaluation step, it circles back on the initiating problem definition. Communities and their policy partners within government, non-governmental organizations (NGOs), researchers and community will continue to assess and redefine the problem again and again.

OAC best practice: community-based participatory applied policy research

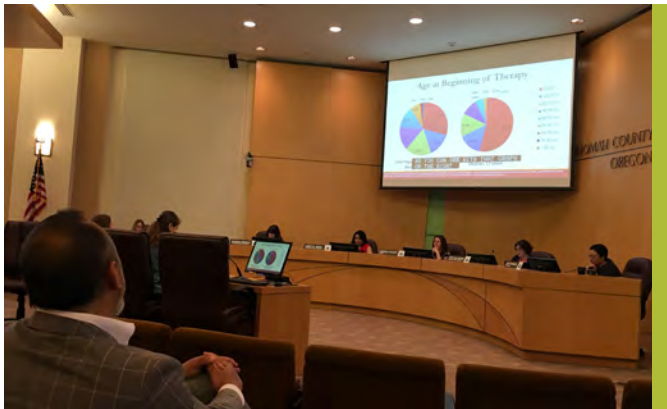


This project's realization of hope for data and research: Four community-based applied policy research studies

This report, with its close examination of how the mental health care system is serving one specific historically marginalized group, is the first of its kind in Oregon. It uses administrative data, qualitative data and quantitative and qualitative analyses for culturally specific community-based participatory applied policy research centering on a historically underserved group. This work was possible thanks to the unique partnership between the Commission on Hispanic Affairs (OCHA), Oregon Health Authority (OHA) and the Oregon Department of Human Services (ODHS) – and the collection of and carefully specified access to data that included race and ethnicity.

Although the collection and maintenance of data for historically underserved groups is a complex, sensitive matter that requires both care and security, having these data is the necessary first step to doing data-driven work centering on historically underserved groups. Additionally, having such data enables analysis of what is working for whom and to what extent, and it sheds light on how practices can be improved for greater positive impact. Importantly, these data also enable and foster transparency in research and practice, a critical aspect of being inclusive, sharing knowledge and establishing equitable policies and services. Collecting such data is necessary for creating any work with the potential to improve service.

Administrative data sets, which remove data traceable to individuals while retaining the overall burden of the data, are key for the community to understand and effectively engage in data-informed policy discussions about themselves. Administrative data sets are the foundation of equitably understanding and using data in public policy. They can be researched with the supervised engagement of graduate level research students in public policy. The regular practice of preparing granular administrative data sets by government is rarer than it should be and may be held back by data collectors concerned about misuse, rhetorical uses, or confidentiality. This seminal report is founded on such a data set, prepared for the research through the collaboration of the OHA and ODHS datamart. Making public such data sets that support policy-related discussion allows the granular public and stakeholders to do their own exploration of the data and present it within their communities in ways that support their nuanced, data-informed viewpoints and advising.



Baker, L. (2018). OCHA presentation to Multnomah County commissioners. [Digital image]. OACO, Portland, OR. Printed with permission.

Every aspect of research design and analysis is colored by the lens that guides it. In other words, concerns about how data are used in research are legitimate and based in reality; like all human endeavors, the perspectives of those leading the work shapes the small, medium and large decisions of whose needs are being prioritized and what biases are built into the work. While this potential for human influence causes a great deal of care and oversight, it is also a reason to have hope for the power of data collected well and research conducted to further equity and drive examination of systems prioritizing the interests of those for whom systems have historically been inadequate. With leadership from individuals from

historically underserved groups and genuine supportive partnership from others, data and research has tremendous potential for furthering equity for all.

OCHA, OHA and ODHS led four applied policy research internship studies of mental health in the Latino/a/x community. Together, these four studies addressed considerations raised by the OCHA commissioners and supported by the Latino/a/x communities that are specific to rural and urban communities as well as youth and adults.

Four community-based applied policy research studies



Table 1: Information about and hyperlinks to OCHA's, OHA's, and ODHS's four applied policy research studies

Study title	Author	Type	Total N	Description of samples
Mental Health Disparities for Latino Oregonians — Report Mental Health Disparities for Latino Oregonians — Presentation	Kimberly Voelker, MPH	Quantitative	N=272,538	Oregonians who initiated mental health care between 1983 & 2013 and terminated between 2010 & 2014 who utilize state-sponsored insurance
Mental Health Service Disparities of Latino Oregonians: A Qualitative Analysis — Report Barriers to Mental Health Service Latinos in Oregonian: A Qualitative Analysis — Presentation	Diana St. Amour, MSW	Qualitative	N=16	Mental health providers – urban + rural
Mental Health Service Disparities in the Latino Population — Report Mental Health Service Disparities in the Latino Population — Presentation	Erin Hernandez, MS	Literature Review	N/A	Rural focus
Access & Barriers to Mental Health Services for Oregon's Latino Population — Presentation	Rebecca Honda, MSW	Qualitative	N=8	Mental health providers — rural

OAC best practice: Prioritizing intersectionality



Joseph Gallegos, PhD, OCHA Commissioner

A set of social justice principles that include a confluence of socio-environmental factors guided the work of the Oregon Advocacy Commissions. Demographic changes in the state have seen a steady increase in the number of Latinos/as/x and other groups of color. There has been a steady increase in the number of Latinos/as/x and allied advocacy and service organizations, more sophisticated and more politically involved than in previous decades. The MeToo movement along with the resurgence of anti-immigrant and white supremacist groups has resulted in a greater coalescence of advocacy efforts among marginalized and allied groups. For OCHA and the other Oregon Advocacy Commissions, the social and political response is couched in the concepts of intersectionality and cultural responsiveness.

- The term intersectionality, coined by Kimberlé Crenshaw, an American civil rights advocate and scholar, describes the overlap of social group categorizations (race, gender, social class, etc.) and their relationships to systems of oppression and discrimination (Crenshaw, 2016).
- The term intersectionality as it relates to mental health is important as the term can help historically underserved groups describe our experiences as we navigate our social and political worlds. As Kimberlé noted in her [Ted Talk](#), when we are unable to name an issue, we are unable to fix the issue (Crenshaw, 2016).

The concept of intersectionality describes the multiple avenues by which people can experience discrimination and oppression. Because of the ethnic and cultural diversity among the groups we call Latino/a/x, even within this label we find intersectionality. For example, among Mexican immigrants, we find many indigenous groups who suffer discrimination even in Mexico for their less than Spanish ancestry. The Puerto Rican Latino/a/x may be treated differently for their African heritage than the Manito (European Spanish heritage) or the Mexican-American individual from the state of New Mexico. Latinos/as/x can be of any race, and cultural variations abound. Thus, cultural responsiveness presents a need for simple yet complex understanding that we label cultural complexity.

In its most simple sense, one need only integrate the concept of culture into a response to mental health needs. However, that response must be processed through a complex of stages that include awareness, knowledge and skill. The first stage of cultural awareness is empathy and a sensitivity to the reality of discrimination and oppression and the structural components that provide the cultural foundation for these repressive elements in our society.



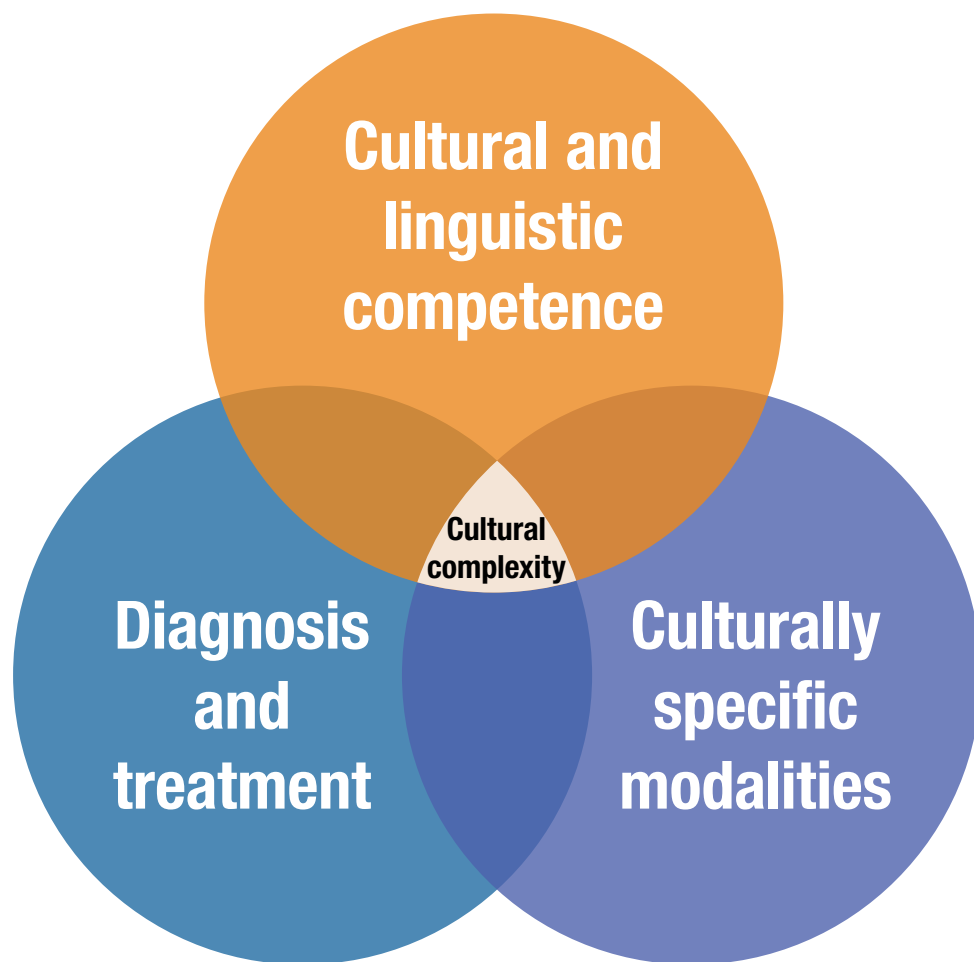
Knowledge of culturally appropriate and best practice models of intervention are the next level required for an effective response. While the practice of providing mental health assistance relies on science as a guide, it is also an art. Practitioners, armed with cultural competence and awareness of systemic oppressions, must not withhold their professional judgment for fear of making mistakes or offending. Rather, working with a client or client system, providers must use their competencies to adjust and adapt best practice modalities to fit the individual circumstance of their client(s).

Individuals and institutions need the capacity and skill to respond appropriately. Capacity to respond means resources — social as well as economic — are available to address needs. Skill to respond appropriately means one has the competence to respond effectively to the need. However, an individual or even an institution is never fully culturally competent, and cultural competence can ebb and flow.

Lack of resources may seriously undercut a provider or an agency's capacity to be culturally competent. To be culturally competent is to continuously assess one's personal and organizational competency status, constantly learning and generating new knowledge and new skills (Gallegos, 2008).

Finally, we propose that the concept of cultural complexity serves as an umbrella term or idea that implies connection between the ideas of cultural competence and intersectionality. Applying cultural complexity to individual or community client service providers may result in the complexity requiring more resources. However, addressing the complexity assures more effective intervention.

Figure 5: Cultural complexity



(The Oregon Advocacy Commissions)

The concept “cultural complexity” is layered and rich; the Oregon Commission on Hispanic Affairs hopes to do more work to fully articulate this concept. For further discussion on this emerging concept of cultural complexity, please see Pages 115–117).

OAC best practice: Partnership and work groups



The OAC bridges community and legislative policy by working collaboratively across organizational and systemic barriers in partnership and work groups.

Figure 6: OAC best practice: partnership



(The Oregon Advocacy Commissions)

State agency partnership is a priority

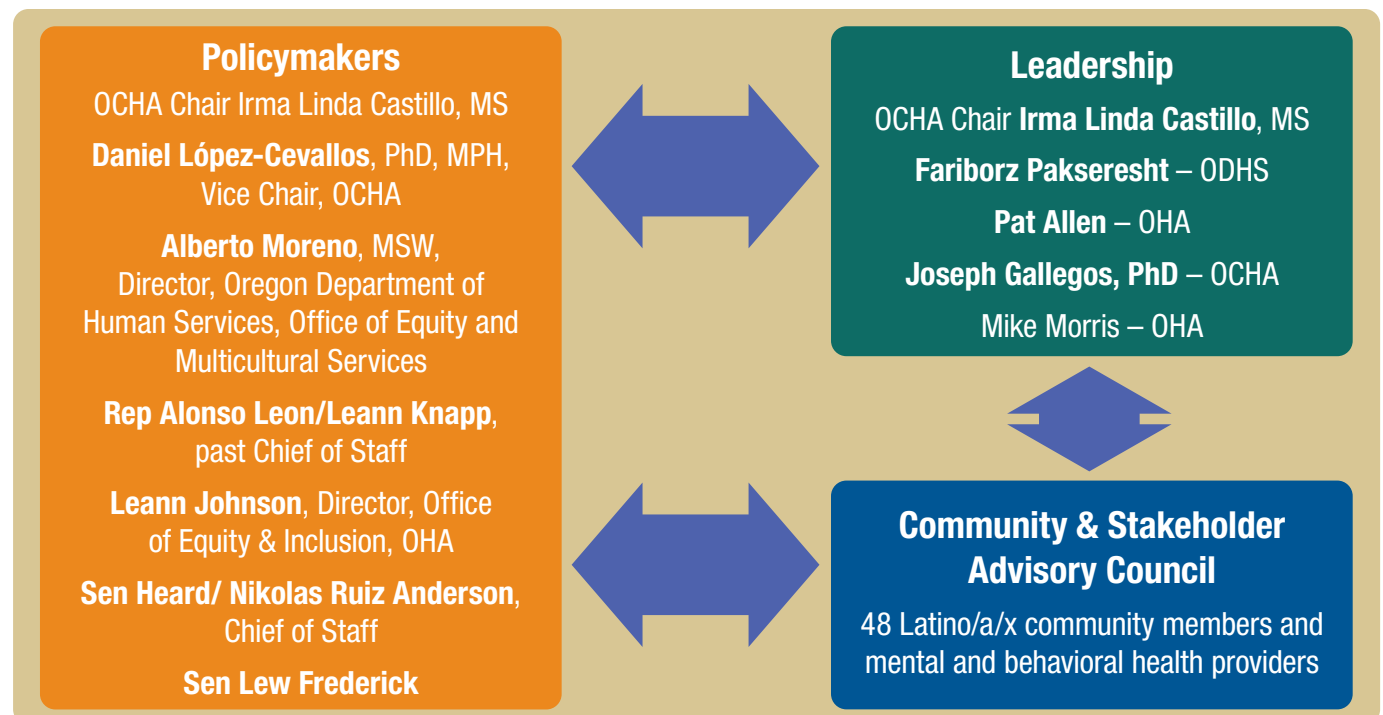
OCHA, OHA and ODHS worked in partnership to develop this work centering on Latinos/as/x and mental health. Together, these agencies shared critical data, conducted research and thought through policy and legislative work with key individuals within and across their agencies.

OCHA serves as the connector between communities' lived experience and needs, and the Legislature's and state agencies' leadership.

Work group collaboration across community members, state leadership and state policymakers at every turn

OCHA led conversations in work groups across partners, sharing applied policy research, learning and disseminating wisdom from community members to agency policymakers and leadership, and strategizing with all three partners to lead change.

Figure 7: Partnership in action



(The Oregon Advocacy Commissions)



Leadership Work Group

The Leadership Group consisted of OCHA Chair Irma Linda Castillo, MS, OCHA Commissioner Joseph Gallegos, PhD, OHA Director Pat Allen, ODHS Director Fariborz Pakseresht, and previous OHA Behavioral Health Director Mike Morris. This group guided the alignment and coordination of the policy work, served as guiding sponsors of the work and outcomes, identified and coordinated staff support and opportunities for data and information sharing as well as other partnership activities for the project.

Policy Work Group

The Policy Work Group consisted of OCHA commissioners, OHA and ODHS staff, state legislators and their staff, and Oregon Advocacy Commissions Office staff. The Policy Work Group conducted an environmental scan of mental health services in Oregon over a series of meetings by inviting subject matter experts to present on their special areas. Those experts provided excellent content and served to raise awareness about the many state agencies, nonprofit and community service providers already engaged in this important work.

Community Advisory Council

The Community Advisory Council (CAC) consists of culturally and linguistically appropriate behavioral and mental health providers who work with Latino/a/x communities, public health educators, community members and legislators. Many people who attended the 2018 Latino Health Equity Conference, which focused on strengthening Latino/a/x emotional and behavioral health, were invited to be members of the CAC because of their expertise, experience and interest in mental and behavioral health. The CAC grew over several months as interested people not yet affiliated with the CAC, who heard about it through their networks, asked to join the meetings and were welcomed.

The CAC shared professional and client experience within the Latino/a/x community with the Policy Work Group, conducted a strengths, weaknesses, opportunities and threats (SWOT) analysis of mental health services in the community, provided feedback, made policy recommendations and developed legislative concepts to move to the Advocacy Commission's Policy Arc (see page 59), and helped the Policy Work Group better understand how the mental health system works and the current internal and external changes that are occurring in the pipeline for supporting and developing mental and behavioral health providers.

OAC Best Practice: Learning from Community Leaders and experts

Environmental scan

The following community leaders and experts in mental health for the Latino/a/x community shared their expertise with the Policy Work Group. This sharing of knowledge and their accompanying collaborative discussions provided rich, relevant information that helped guide this work's recommendations and direction.

Governmental systems

Shelley Das, Office of Equity & Inclusion,
Oregon Health Authority (OHA)
Multnomah County Commissioner Sharon
Meieran, JD, MD

Youth and school-based services

Maureen Hinman, Director of Policy and
Strategic Initiatives, School-Based Health
Alliance (SBHA)
Diana Hall, Senior System and Policy Analyst,
Youth and Family Services Division,
Multnomah County
Maria Velez, Associate Director of Schools
Uniting Neighborhoods (SUN) Community
Schools,
Latino Network
Sarai Rodriguez, SUN Community Schools Regional Manager, El Programa Hispano Católico
Pedro Villagomez, SUN Community Schools Site Manager at Wilkes Elementary,
El Programa Hispano Católico



Hernandez, William. (2012). El Retorno del Chasqui. [Acrylic on canvas]. Reprinted with permission.



Community services and advocacy

Marilou Carerra, RN, MPH, Community Health Equity Manager, Oregon Health Equity Alliance (OHEA)

Holden Leung, Executive Director, Asian Health & Service Center

Health analytics/evaluation

Wes Rivers, Healthy Teens Survey, Public Health Division, Oregon Health Authority

Community care organizations (CCOs)

Jeremiah Rigsby, JD, Chief of Staff, CareOregon

Professional pipeline

Anthony Medina, Task Force, Office of University Coordination, Higher Education Coordinating Commission (HECC)

Rural profile

Daniel López-Cevallos, PhD, MPH, Associate Professor, School of Language, Culture & Society, Oregon State University and OCHA Vice Chair



The Latino/a/x communities in Oregon

The Latino/a/x communities in Oregon

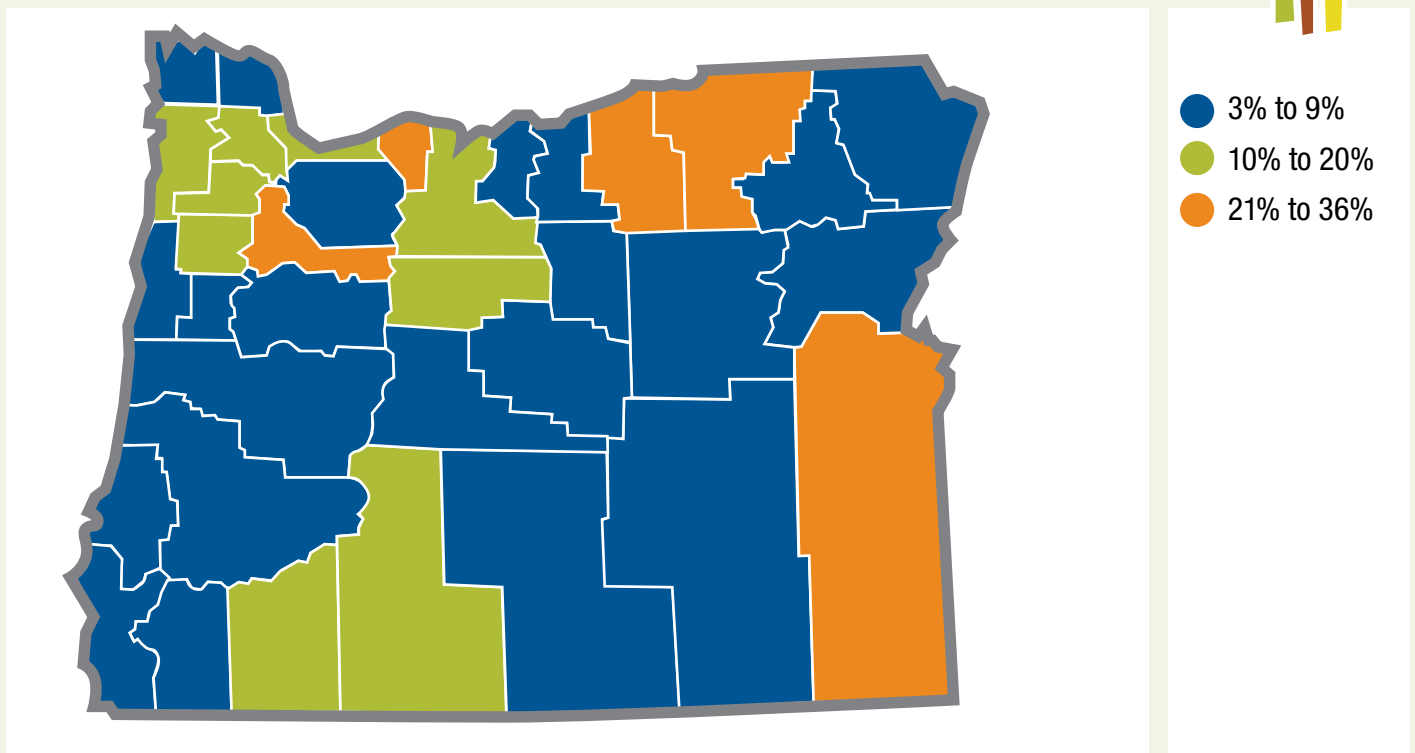


This section of the report uses the findings of the various needs assessment studies done by OCHA's, OHA's and ODHS's interns. It also uses other research relevant to the Latino/a/x communities to present data regarding the Latino/a/x presence in Oregon.

Oregon's Latino/a/x population lives across the state

Approximately 13% of Oregon's population identifies as Latino/a/x (n=540,924). Among this population, approximately half identify as female (48.1%), and the median age is 25.6 years old. In those older than 15, 43.2% of the population is married (U.S. Census Bureau, 2017). Census population estimates from 2017 identify the counties with the largest proportion of Latino/a/x residents are Morrow (36.2%), Malheur (24.0%), Hood River (31.3%), Umatilla (26.8%) and Marion (26.7%).(University of Wisconsin Population Health Institute, 2019).

Figure 8: Percent of Oregon's population that is Latino/a/x, 2017



(U.S. Census Bureau, 2017, University of Wisconsin Population Health Institute, 2019)



The Latino/a/x population in Oregon is growing rapidly

The Latino/a/x population in Oregon is growing at a rapid rate. Although the Latino/a/x population makes up a greater proportion of the population nationally than in Oregon (17% nationally compared to 12% in Oregon), Oregon's Latino/a/x population is growing at a faster rate than the rest of the country. The growth of the Latino/a/x population in Oregon has been widespread and spans across the state's 36 counties, with most of this growth happening on the west side of the state (U.S. Census Bureau, 2017).

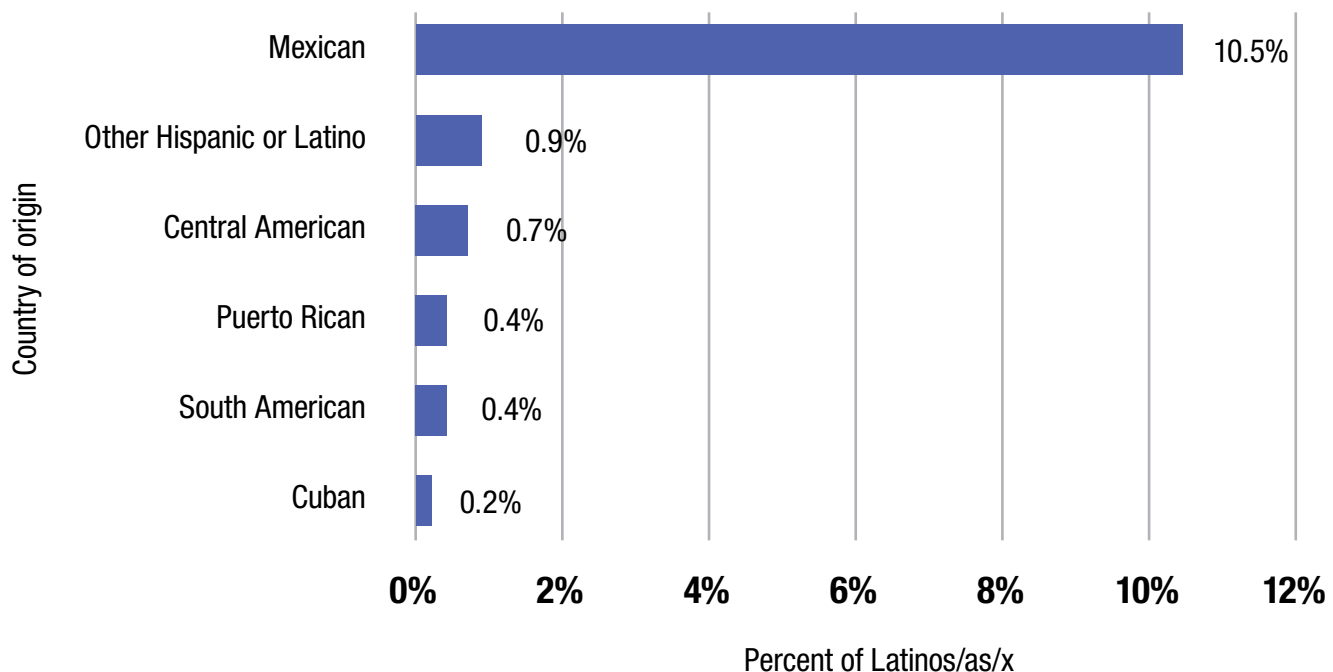
Although immigration explains some of this growth in the Latino/a/x population, the growth rate of native-born Latino/a/x persons has been higher than foreign-born (21% growth rate compared to 1%) (Ruffenach, et al., 2016).

The community's diversity is also growing

Many Latino/a/x people indicate that being Latino/a/x is part of their racial and/or ethnic identity, and many Latino/a/x people further identify with their family's country of origin.

While most Latino/a/x people in Oregon have Mexican roots, the number of people who identify as Central American, South American, Puerto Rican and Cuban has more than doubled over the past 20 years. The Mesoamerican community in Oregon, as reflected in the diversity of languages described in the following section, also has a strong presence in Oregon.

Figure 9: Percent of Oregon population with Latino/a/x origin, 2017



(U.S. Census Bureau, 2017)

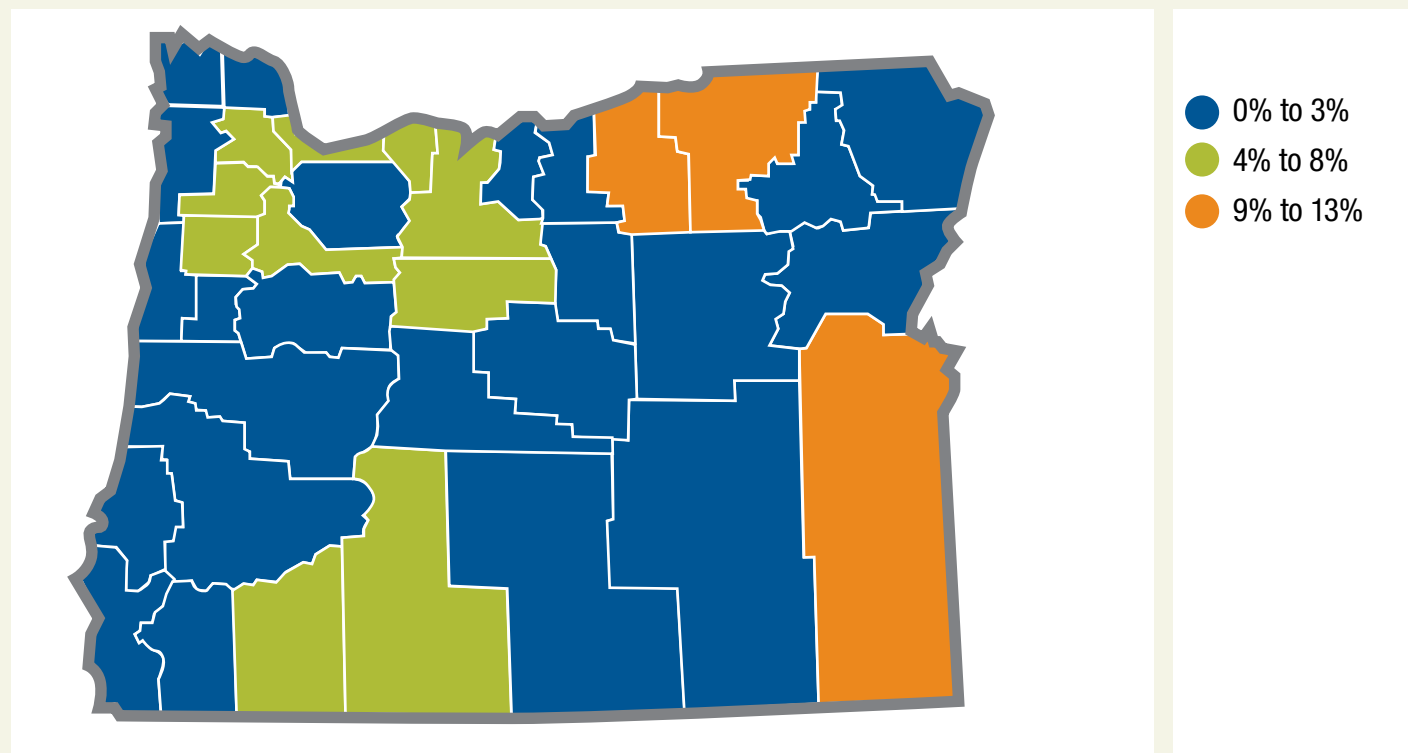
Approximately two-thirds of the Latino/a/x population living in Oregon was born in the United States (66.9%). Among the foreign-born Latino/a/x people living in Oregon, 30% are naturalized citizens (U.S. Census Bureau, 2017).

Linguistic diversity in Oregon

The majority of Latinos/as/x in Oregon speak Spanish at home, but nearly half speak Spanish and English. Approximately one-third use English as their primary language, and the number of Spanish-dominant Latinos/as/x people in Oregon with limited English skills is declining (Ruffenach, et al., 2016). The counties with the largest Spanish-speaking population include Malheur, Morrow, Umatilla and Hood River (Oregon State Legislature, 2015).

Although the census does not collect specific data on the types of indigenous languages spoken, research suggests that Mixteco Alto, Mixteco Bajo, Triqui, Zapoteco, Náhuatl, Poqochi, Purépecha, Akateco, Kanjobal, K'iche' (or Quiché) and Mam are some of the more common Mexican and Guatemalan indigenous languages spoken in Oregon (Peters, 2014; Stephen, 2017). With increased estimates regarding the number of indigenous migrant and seasonal workers in Oregon, this list of common indigenous languages is dynamic and evolving — and by no means exhaustive. Data

Figure 10: Percent of voting-age citizens who speak Spanish by county, 2009-2013



(Oregon State Legislature, 2015)

from Oregon's Court Language Access Services indicate the number of requests for indigenous languages—including Mam, Q'anjob'al and K'iche'—has been increasing across the state, particularly in Marion, Umatilla and Multnomah counties (Ramakrishnan, 2018; Rahe, 2018).

K'iche' is a Maya language of Guatemala, spoken in the central highlands (departments of El Quiché, Totonicapán, Quetzaltenango and Sololá). K'iche' is the second most widely spoken language in Guatemala after Spanish, with more than one million speakers.

Mam is a Maya language spoken by about half a million people in Guatemala, mainly in the departments of Quetzaltenango, Huehuetenango and San Marcos. It is also spoken in the Mexican state of Chiapas along the border with Guatemala. There are three main varieties: Northern Mam, Southern Mam and Central Mam; each has many sub-dialects.

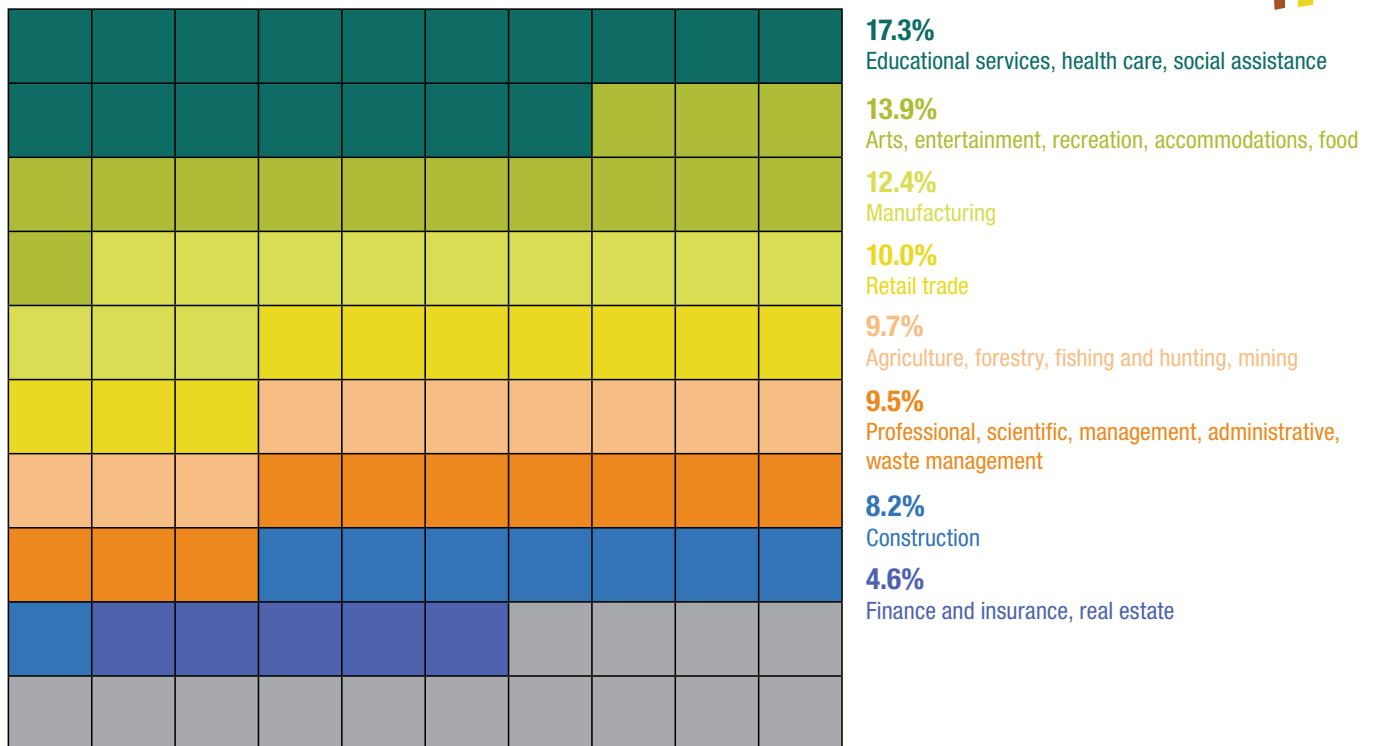
Purépecha is the language and name of indigenous people from the state of Michoacán, Mexico. The state of Michoacán, located in central Mexico, has been a primary Mexican sending community to the Oregon workforce since the late 1980s. Purépecha may also be known by their Spanish name, Tarascan. A significant community of these individuals has settled in Clackamas and Washington counties.

Q'anjob'al is also a Maya language spoken primarily in the Huehuetenango department of Guatemala and in the Mexican state of Chiapas. 2003 data indicate there are approximately 150,000 native speakers.

Two-thirds of Oregon's Latino/a/x population are employed

68.1% of Latino/a/x people over age 16 in Oregon are employed, 3.4% are unemployed, and 28.4% are not in the labor force. The Latino/a/x unemployment rate in Oregon is 4.8% (U.S. Census Bureau, 2017). Nationally, U.S. born Latinos/as/x account for approximately 52% of the workforce (Flores, 2017). Latinos/as/x in Oregon are most commonly employed in educational services, health care, social assistance, health care, social assistance, arts, entertaining, recreation, accommodation, food and manufacturing.

Figure 11: Industries employing Latinos/as/x, Oregon, 2017



Other industries: 3.9% public administration; 3.4% other; 3.1% transportation and warehousing; 2.7% wholesale trade; and 1.2% information.

(U.S. Census Bureau, 2017)



Researchers estimate approximately 172,611 migrant and seasonal agricultural workers and family members are in Oregon. Among the 86,389 migrant and seasonal farmworkers themselves, there are more seasonal (57,449) than migrant (28,940) workers. Wasco, Marion, Hood River, Washington, Yamhill and Clackamas counties have the largest migrant and seasonal farmworker populations (Rahe, 2018).

In 2017, the median income for Oregon's Latino/a/x population was \$23,979, compared with \$32,970 for non-Latino/a/x whites (U.S. Census Bureau, 2017). Nationally, Latino/a/x Americans were disproportionately affected by economic losses during the Great Recession, and income levels have been slow to recover (Flores, 2017).

Latino/a/x health and mental health



Latinos/as/x in Oregon have health insurance, but are more likely to report “poor or fair health” than other groups

According to American Community Survey 2017 estimates, 83.7% of Latinos/as/x in Oregon have health insurance, with an almost even split between private versus public coverage (U.S. Census Bureau, 2017). This is an improvement compared to 2014 estimates, when over one-quarter of Latino/a/x communities in Oregon were uninsured (Ruffenach, 2016).



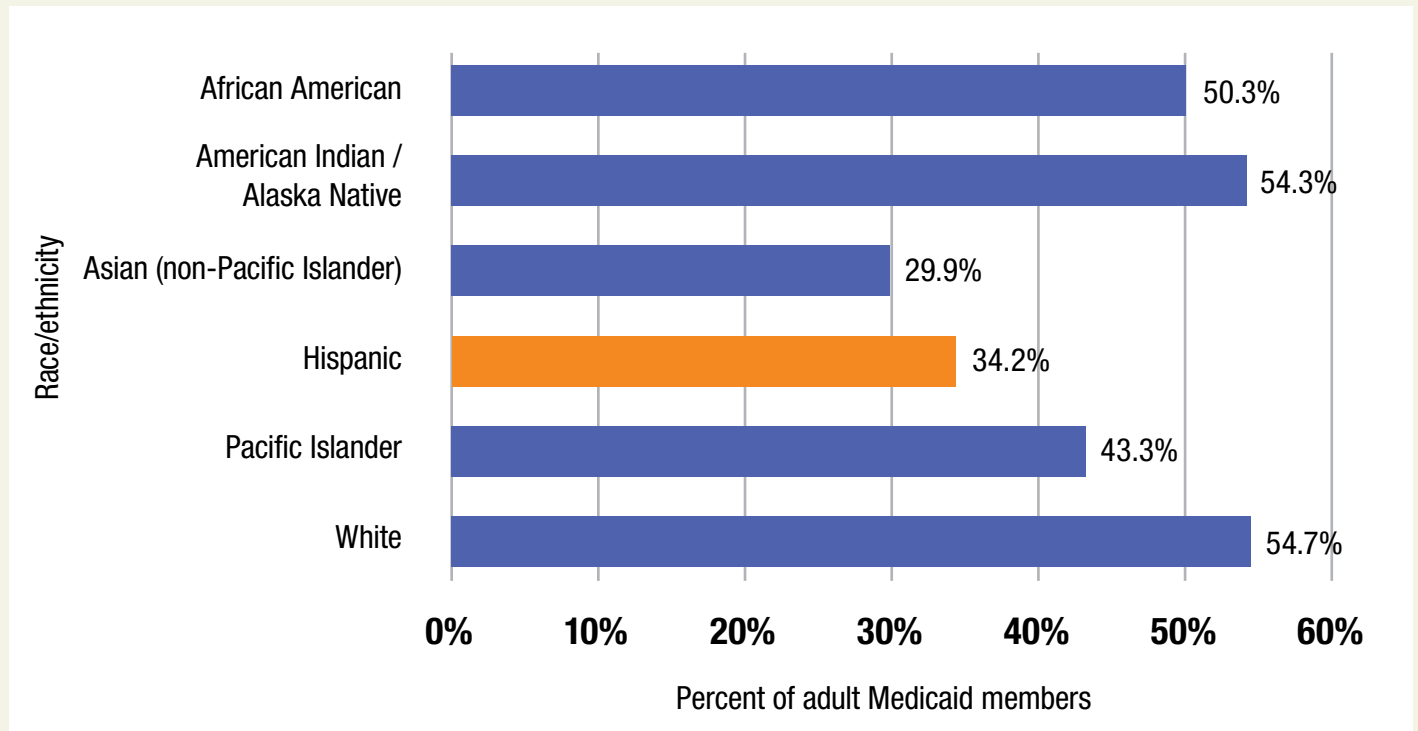
Hernandez, William. (n.d.). Keep the Light in the House Low. Reprinted with permission.

Data from the Robert Wood Johnson Foundation’s (n.d.) Annual County Health Rankings indicates that 26% of adult Latinos/as/x in Oregon report “poor or fair health” compared to 14% of white adults and 11% of Asian/Pacific Islander adults, although Latino/a/x adults fare better than American Indian/Alaska Native (AI/AN) adults (20%). Latino/a/x adults in Oregon report on average 4.1 poor mental health days in the past 30, better than an average of 4.6 days for white adults, and 7.0 days for AI/AN adults (University of Wisconsin Population Health Institute, 2019).

Among Oregon’s Medicaid population, almost half of Latino/a/x adults reported that their usual activities were limited by poor physical or mental health at least one day of the last 30, and a third of Latino/a/x adults reported that their mental health was “not good” at least one of the past 30 days. Causes include stress, depression and problems with emotions (Oregon Health Authority, Medicaid Behavioral Risk Factor Surveillance System).



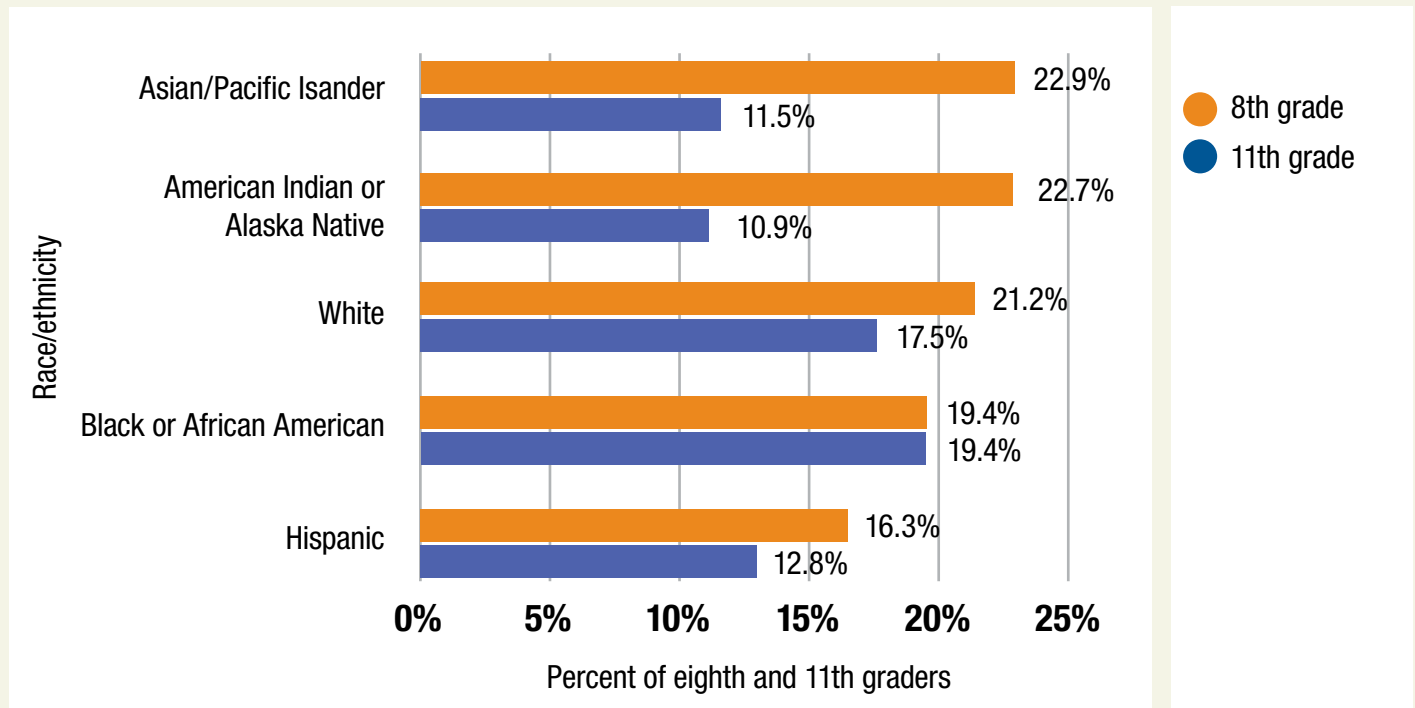
Figure 12: Percent of adult Medicaid members who report their mental health was “not good” one or more of the last 30 days



(Oregon Medicaid Behavioral Risk Factor Surveillance System Survey, 2014)

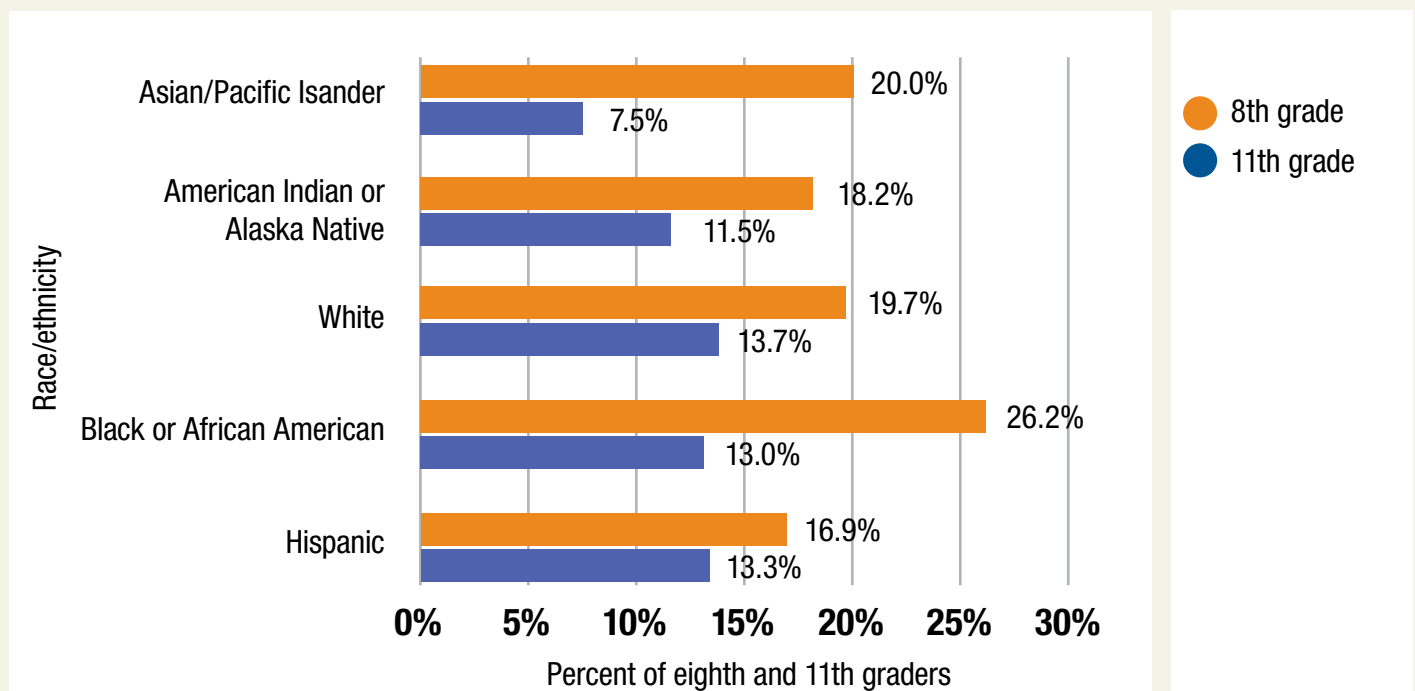
Data from the 2017 Oregon Healthy Teens Survey find that Latino/a/x eighth and 11th graders were less likely to report “excellent” physical health than their non-Latino/a/x peers. Latino/a/x eighth and 11th graders were also less likely to report that their emotional or mental health was “excellent” (Figure 13).

Figure 13: Percent of eighth and 11th graders reporting “excellent” physical health, 2017



(Oregon Medicaid Behavioral Risk Factor Surveillance System Survey, 2014)

Figure 14: Percent of eighth and 11th graders reporting that their emotional and mental health was “excellent,” 2017



(Oregon Medicaid Behavioral Risk Factor Surveillance System Survey, 2014)

Spotlight: Depression

There are known disparities in recognizing and treating depression for Latino/a/x people in the United States. A mental health provider must know how to identify symptoms in the context of the Latino/a/x culture in order for depression to be diagnosed. Language differences, client understanding of how to discuss health concerns in the U.S. healthcare system, and mismatch between what the provider expects to hear versus the client's description of physical presentation all lead to providers under-recognizing depression for Latinos/as/x. For example, Latino/a/x people may be more likely to experience depression in the form of bodily aches and pains, or as feeling nervous or tired, and may culturally have greater tolerance for negative emotions (Rios-Ellis, 2005; Tsai & Chentsova-Dutton, 2002). Accuracy rates may vary across screening tools that may not have been tested with Latino/a/x populations (Reuland et al., 2009; Maxson, 2009).



Hernandez, William. (n.d.). The Most Beautiful Poem for You. Reprinted with permission.

The lifetime risk of depression in Latino/a/x communities also varies across those who have immigrated compared to those who were born in the United States (Alegría et al., 2008; Lewis-Fernandez et al., 2005; Rhynard, 2012). While Latino/a/x communities may have similar prevalence of depression compared to other race/ethnicities, it is important to recognize variation within the population, as well as recognizing that, once identified, Latino/a/x people with depression are also less likely to receive treatment.

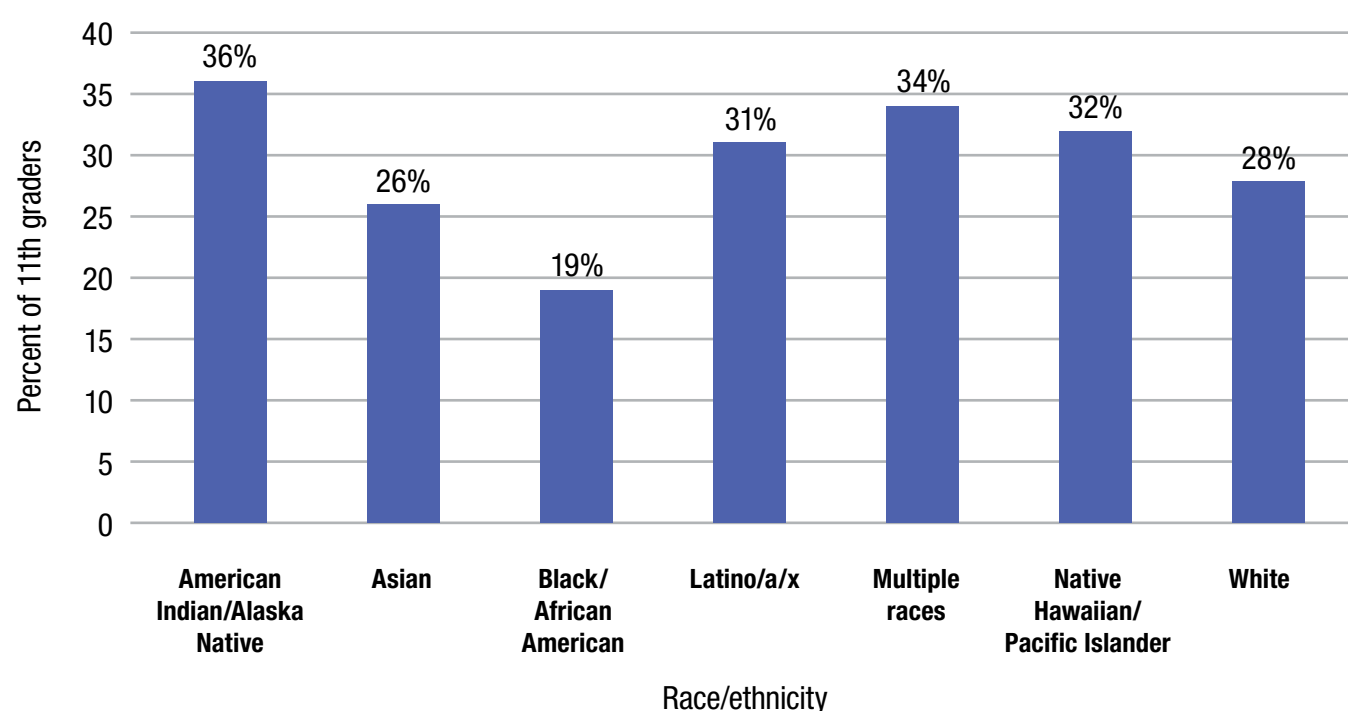
Adults

According to data from the Centers for Disease Control and Prevention, 19.5% of Latinos/as/x in Oregon have ever been told that they have a form of depression (Oregon Health Authority, Medicaid Behavioral Risk Factor Surveillance System). Similarly, 20.4% of Latino/a/x Medicaid members report having been told they have depression (Oregon Health Authority, Medicaid Behavioral Risk Factor Surveillance System).

Teens

31% of Latino/a/x youth reported depressed mood for two weeks in 2015.

Figure 15: Oregon youth reporting depressed mood for two weeks of the last year, 2015



Note: All race groups are non-Hispanic. [Currently, the U.S. Census Bureau counts the category “Hispanic” as an ethnicity, not a race (U.S. Census Bureau, 2020).]

(Oregon Healthy Teens Survey)

Cultural factors and traditional beliefs

Cultural values are not universal; there is variation within groups. What is typical for the group as a whole may not be true for individuals. This section includes broad generalizations about Latino/a/x cultural factors and beliefs that may not apply to all communities or individuals. Latino/a/x identity may change over time and generations; among Latino/a/x individuals who are foreign born, 59% participated in cultural traditions while growing up, while only 35% of third generation or higher US-born Latinos/as/x did (Pew Research Center, 2007).



Multiple cultural factors influence when and how Latinos/as/x choose to seek care

Latino/a/x culture tends to value group activities, shared responsibility and collective accountability. Harmony and cooperation may be emphasized more than individual function and responsibility (Gudykunst, 1998). Individuals look to each other for opinions and advice, which can help spread health promotion messages quickly, but can also magnify negative experiences with the current behavioral health system.

The dominant cultural behavioral health system tends to value the individual and independence, whereas Latino/a/x culture values interdependence and a reliance on social networks and communities. When individuals experience a disconnect between the dominant mental health care model and their own values, they are more likely to drop out of care, or not initiate care based on others' experiences (St. Amour, 2017).

Latinos/as/x almost universally value family considerations over individual or community needs. *Familismo* is the expression of strong loyalty, reciprocity and solidarity among family members at all levels (nuclear, extended and close friends) (Smith, 2000). Providers working with Latino/a/x clients may find their focus needs to be on the family, not on the individual, which may take additional resources and may conflict with certain mainstream practices around patient privacy.

A 2017 study of mental health disparities among Latinos/as/x in Oregon highlighted the critical importance of family and community (St. Amour, 2017), and community listening sessions across Multnomah County identified a need for even more focus on families in mental health services (Human Services Research Institute, 2018).

Stakeholders described a lack of emotional support, education about mental health needs, information about how the system worked and options for finding help for loved ones with unmet needs (Human Services Research Institute, 2018). Many Latino/a/x patients seeking care will have already sought help from family resources (Medina, 2014). Mental health is often considered a family matter to be dealt with in the home, rather than seeking outside help.

“*There is shame and stigma regarding mental health in general so, accessing services outside of the home in a very specific way, like going to a mental health clinic, is not something that we see as often for [the Latino/a/x population].*”

— Oregon Bilingual/Bicultural Provider
(Honda, 2019)



Latino/a/x values of *simpatia* (kindness), *personalismo* (friendliness), and *respeto* (respect) are also important to recognize in clinical settings (Juckett, 2013). *Personalismo* (friendliness) is an essential quality for providers to have, as many Latinos/as/x may expect health care personnel to be warm and personal, and to treat them with dignity and respect, especially for older adults. A brusque health care provider may not learn of significant complaints or problems and find the patient unlikely to return (Medina, 2014). Asking traditional screening questions to identify a diagnosis will not be accurate or effective for Latino/a/x clients (Honda, 1996).

The majority of Latino/a/x people are religious and are more active in faith and church communities than Americans as a whole (Pew Research Center, 2007). While most Latinos/as/x use modern medical care as their primary sources of health care, some may rely on traditional healing, including home remedies and folk healers. This may be due to lower cost and greater availability of folk remedies compared with health services. Some may use folk and/or herbal medicine in combination with medications shared by a friend or family member, or medications prescribed by their own providers (Medina, 2014).

Traditional beliefs

Some Latino/a/x people believe that health results from good luck, or is a reward for good behavior (Spector, 1996). Illnesses are thought to have either natural or supernatural causes and Latinos/as/x may have spiritual interpretations of mental or emotional health conditions. Some traditional beliefs on illness, causes, and remedies include the following (Centers for Disease Control and Prevention, 2015):

- Physical or mental illness may be attributed to an imbalance between a person and the environment, expressed as either “hot” and “cold” or “wet” and “dry” (Spector, 1996; Kemp & Rasbridge, 2004). In general, cold diseases/conditions are characterized by vasoconstriction and low metabolic rate (e.g. cancer, colic, pneumonia), and hot conditions are characterized by vasodilation and high metabolic rate (e.g. pregnancy, hypertension, diabetes) (Juckett, 2013). To correct an imbalance, people consume foods or herbs with the opposite quality (e.g. “cold” conditions are treated with “hot” medications) (Smith, 2000; Medina, 2014).
- **Empacho** is a form of upset stomach or indigestion that some believe is caused by undigested food getting stuck to the walls of the stomach or intestines, causing an obstruction. It results from overeating, not chewing food completely, consuming spoiled foods, eating at the wrong time of day, or combining the wrong foods. Symptoms include anorexia, vomiting, diarrhea, bloating, cramps and stomachache. Treatment includes dietary



restrictions, herbal teas, abdominal massage with warm oil and pinching the skin on the back (Smith, 2000; Spector, 1996; Carteret, 2010).

- **Mal de Ojo**, or “evil eye,” is caused when someone looks with admiration or jealousy at another person, or an unconscious hex is placed on a child. The person looked upon experiences illness, sleepiness, fatigue and headaches. Folk remedies include saying a prayer while passing an egg over the victim’s body, then placing the egg in a bowl under their bed overnight, having the person who caused the *mal de ojo* care for the victim, or wearing charms for protection (Juckett, 2013; Kemp & Rasbridge, 2004).
- **Nervios** is a term for worry, jumpiness, irritability, depression, agitation and nervousness. While data are not available for Oregon farmworkers, estimates of *nervios* in farmworkers in other states have found rates higher than one in five, as well as high rates of depression and anxiety (National Center for Farmworker Health, 2018).
- **Susto**, or fright resulting in “soul loss” or “soul sickness,” arises from a traumatic or frightening experience and is thought to cause the soul to leave the body to wander freely (Kemp & Rasbridge, 2004). Symptoms include anxiety, depression, insomnia, introversion, irritability, lethargy, anorexia and other vague complaints. Treatments include herbal teas, covering the face with a cloth and sprinkling holy water, and cleansing ceremonies performed by spiritual healers (Carteret, 2010).



Access to mental health care for Oregon Latinos/as/x



Adams, Tamara. (2017). Wish for Our Daughters. [Acrylic on canvas]. Reprinted with permission.

Access to mental health care for Latinos/as/x in Oregon



This section of the report uses the findings of the various needs assessment studies done by OCHA's, OHA's and ODHS's interns, and other research relevant to the Latino/a/x communities in Oregon, to present data regarding mental health access for Oregon's Latino/a/x communities.

Where and how do Latinos/as/x in Oregon receive mental health care?

Compared with other groups, Latinos/as/x in Oregon are less likely to seek mental health care

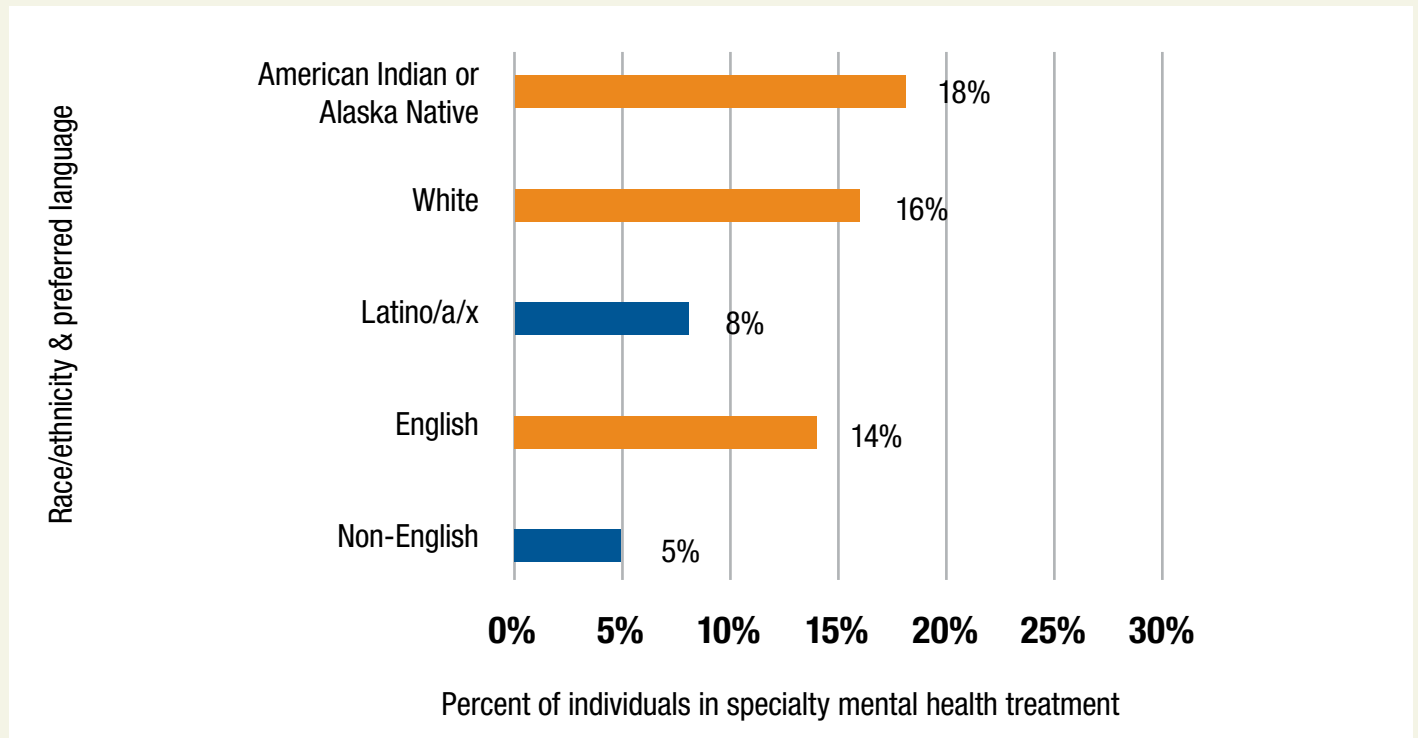
Several studies have found that Latinos/as/x tend to access mental health services at low rates when compared with non-Latino/a/x whites (Cabassa et al., 2006; Lee et al., 2017; Cook et al., 2013). This low rate of seeking mental health services does not reflect a lack of need for treatment, but rather receiving care only in crisis situations (Miranda et al., 2004). A surgeon general's report found that only 20% of Latinos/as/x who had symptoms of psychological disorders spoke with their health provider (National Alliance on Mental Illness, n.d.).

Oregon has seen similar patterns in mental health treatment, with Latinos/as/x accounting for approximately 10% of mental health encounters within the county mental health system in Oregon, despite making up a larger share of the population as a whole (Voelker, 2017). A review of Oregon administrative data found that Latino/a/x adults received crisis services from the county mental health system at lower rates compared with the general population (36.5% for Latino/a/x adults, compared with 38.3% for all adults) (Voelker, 2017).

A recent report also suggested that among Multnomah County's Medicaid enrollees, the specialty mental health treatment [special health care services for people who have a mental illness or emotional problems that a regular doctor cannot treat (San Bernardino Behavioral Health, n.d.)] penetration rate was only 8% among Latinos/as/x, compared with 18% among American Indians and Alaska Natives and 16% among non-Latino/a/x whites. When trends were compared across preferred languages, treatment disparities were even more apparent. The specialty behavioral and mental health service treatment penetration rate was only 5% among those who spoke a language other than English, compared to 14% among English speakers (Human Services Resources Institute, 2018).

Among youth who reported recent suicidal thoughts, one study found that Latino/a/x adolescents were half as likely as their white peers to have sought mental health services (Freedenthal & Stiffman, 2007). Among youth who experienced a mental health crisis resulting in a visit to an

Figure 16: Specialty mental health treatment penetration in Multnomah County is lower for Latinos/as/x and those who do not speak English as a first language, Fiscal Year 2017



(Human Services Resources Institute, 2018)

emergency department, Latino/a/x youth were significantly less likely to have received any mental health care in the months leading up to the crisis (Snowden et al., 2009).

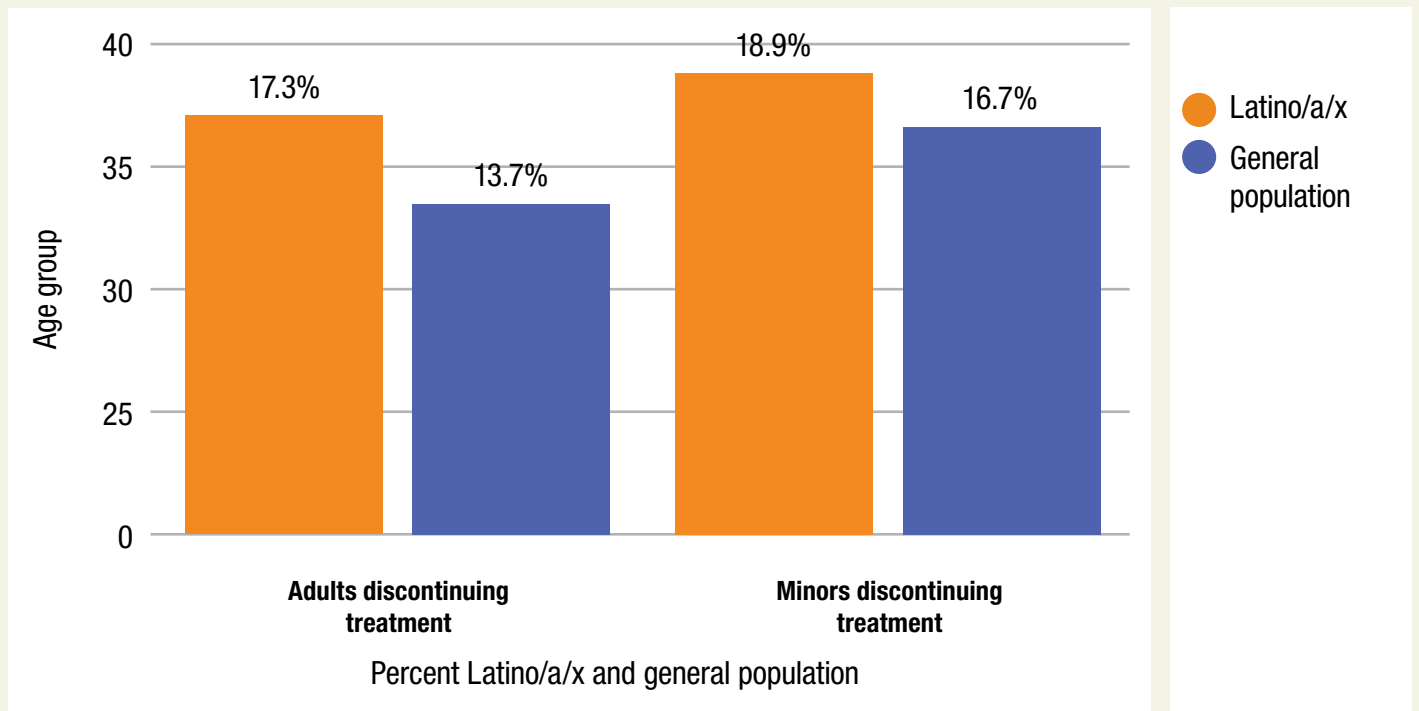
The percentage of Latino/a/x minors receiving psychiatric residential treatment from county mental health services was roughly half the percent of all minors who did so (1.7% for Latinos/as/x compared with 3.2% for all groups) (Voelker, 2017). A smaller percentage of Latino/a/x minors received any crisis services (9.54% versus 11.48%) compared with other minors, while a larger percentage received child or adolescent basic outpatient services (85% versus 82%) (Voelker, 2017).

Mental health treatment for the Latino/a/x communities in Oregon is less likely to be completed or of adequate quality

In addition to being less likely to receive mental health treatment, Latinos/as/x who do receive treatment are more likely to forego services sooner and tend to receive a lower quality of care (Miranda et al., 2004).

Among youth who had a major depressive episode, non-Latino/a/x youth were one and a half times more likely to have received adequate treatment before the crisis than Latino/a/x youth (Alexandre et al., 2009). In a review of 30 years of Oregon administrative data, only 11% of Latino/a/x adults and 24% of Latino/a/x minors receiving treatment through the county mental health system discontinued treatment because it was considered complete; the most common reason for Latinos/as/x discontinuing treatment was needing short-term crisis services (Voelker, 2017). This review also found Latinos/as/x in Oregon were also more likely than other groups to discontinue mental health care against their clinician's advice (Voelker, 2017).

Figure 17: The Latino/a/x communities in Oregon receiving county mental health services were more likely to discontinue mental health treatment against advisement than other groups



(Voelker, 2017)



The Latino/a/x population that received county mental health services in Oregon over the last several decades was concentrated in the Willamette Valley

County mental health services are an important component of the mental health care system for Latinos/as/x in Oregon. A review of data* from 1983–2013 revealed that more than half of the Latinos/as/x in Oregon who received county mental health care during this period (61.9%) were located in Multnomah, Washington, Yamhill, Polk and Marion counties (Voelker, 2017). Across the state, the vast majority of these Latino/a/x patients received treatment from county mental health providers located in the same county where they lived, similar to non-Latino/a/x groups (94% vs 93%) (Voelker, 2017). Approximately 3% of Latinos/as/x traveled across county lines to access treatment.

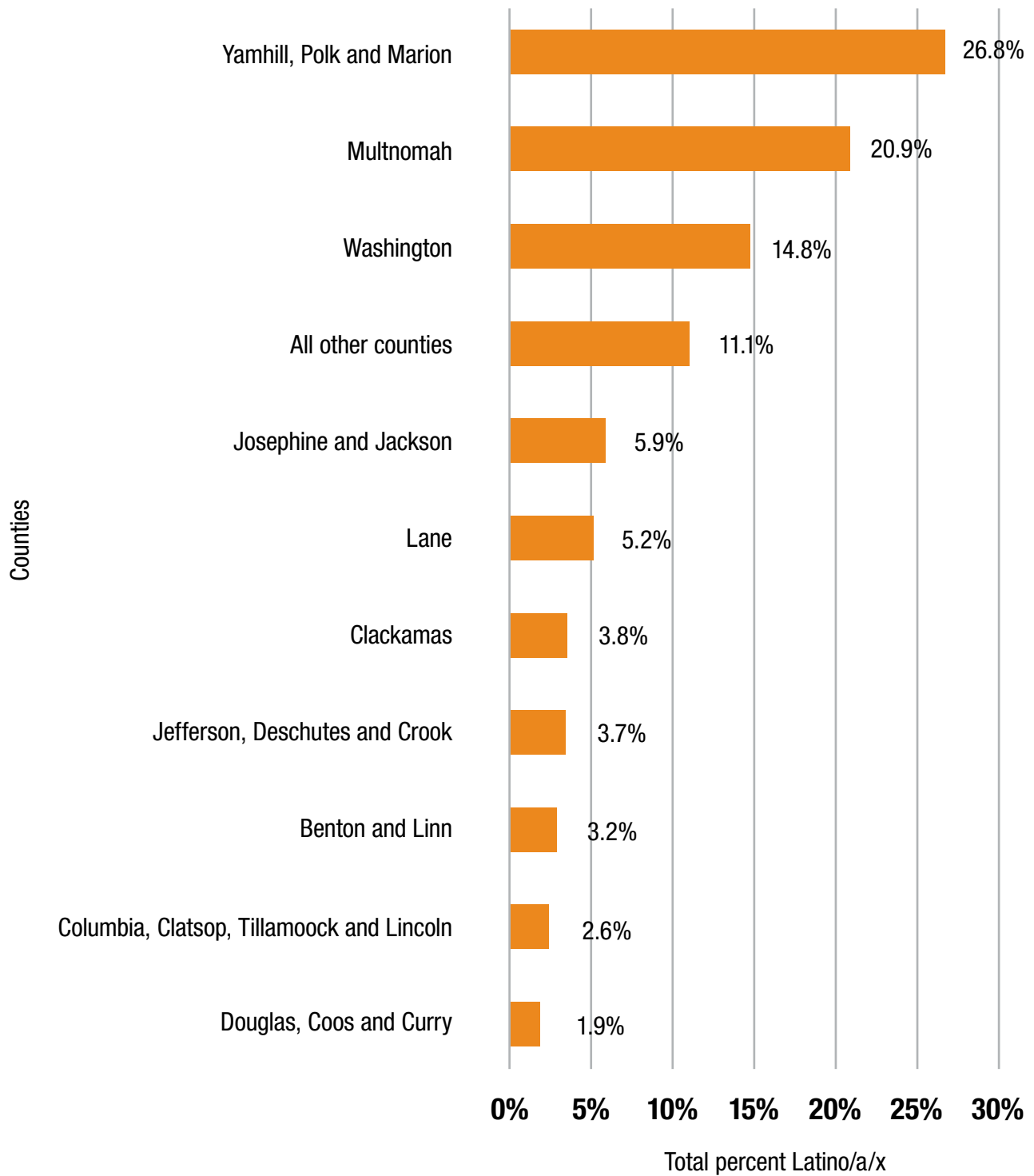
However, settings where care was accessed and delivered varied for Latinos/as/x and non-Latinos/as/x by rural/urban geography. Rural living was positively associated with seeking mental health care from primary care providers (Vega et al., 1999), and primary care providers were a top referral source for Latinos/as/x who did seek mental health care in Oregon (Voelker, 2017). This is noteworthy because Latinos/as/x in Oregon are less likely than other groups to have an assigned primary care provider.

* These data reflect individuals who interacted with the county mental health system, and do not include those who received mental health services through Medicaid or other insurance, or from other mental health providers outside the county.

These data should be interpreted with some caution because (1) there may be differences between Latinos/as/x in Oregon who used county mental health services and those who used other forms of mental health care; and (2) these data collected between 1983 and 2013 measure racial and ethnic groups in broader categories than current mental health data collection, which captures more specific sub-groups.



Figure 18: County of residence for Latinos/as/x in Oregon who received services from the county behavioral health system between 1983 and 2013



(Voelker, 2017)

What influences access to mental health care?

Latinos/as/x in Oregon who are more socially connected and born in the United States are more likely to access mental health care

Research in Oregon suggests that having immediate family in the state (Ruiz et al., 2013) and attending church (López-Cevallos et al., 2014) were associated with Latinos/as/x accessing health services (including mental health services). Working full-time and being enrolled in school were also predictive of accessing health services among Oregon's Latino/a/x farmworkers (López-Cevallos et al., 2012).

Factors negatively associated with use of mental health services include being born outside the United States or having low acculturation, not knowing where to seek services, experiencing economic strain, and having a smaller network of social support (Cabassa et al., 2006).

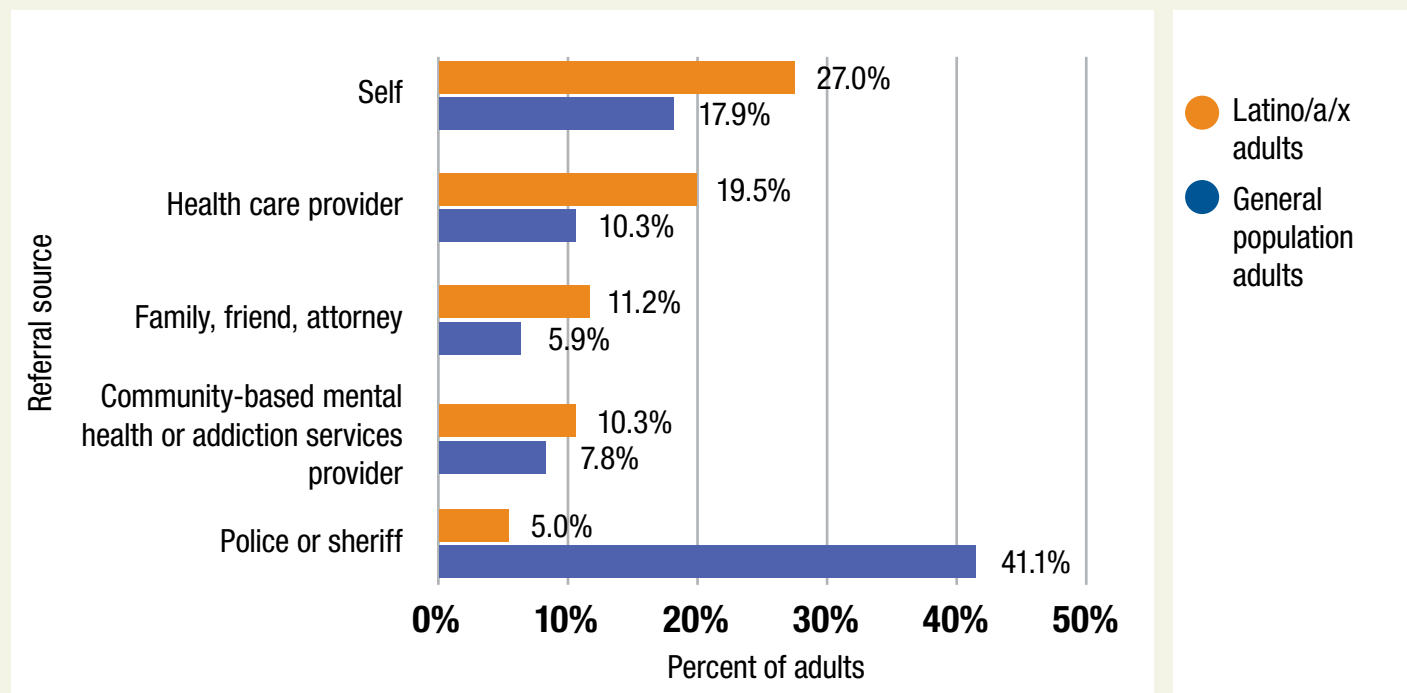
Health care providers, friends and family are important referral sources among Latinos/as/x in Oregon who access services through the county mental health system

Notably, while police made 41% of all adult referrals to county mental health services in Oregon, police referred only 5% of Latino/a/x adults to county mental health services. Self-referrals and those made by health care providers, family and friends were much more likely for Latino/a/x adults than the general population (Voelker, 2017).



Adams, Tamara. (n.d.). *Our Lady of Guadalupe*. [Acrylic on wood]. Collection of Alberto Moreno. Portland, OR. Reprinted with permission.

Figure 19: Top referral sources* to county mental health services for Latino/a/x adults, compared to general population adults



* Referral source indicates the institution, agency or person that takes deliberate action to ensure the client is seen by a health provider. Examples include bringing the client to an appointment, writing letters and making phone calls to set up appointments.

A deliberate action is not a suggestion from someone to receive mental health care.

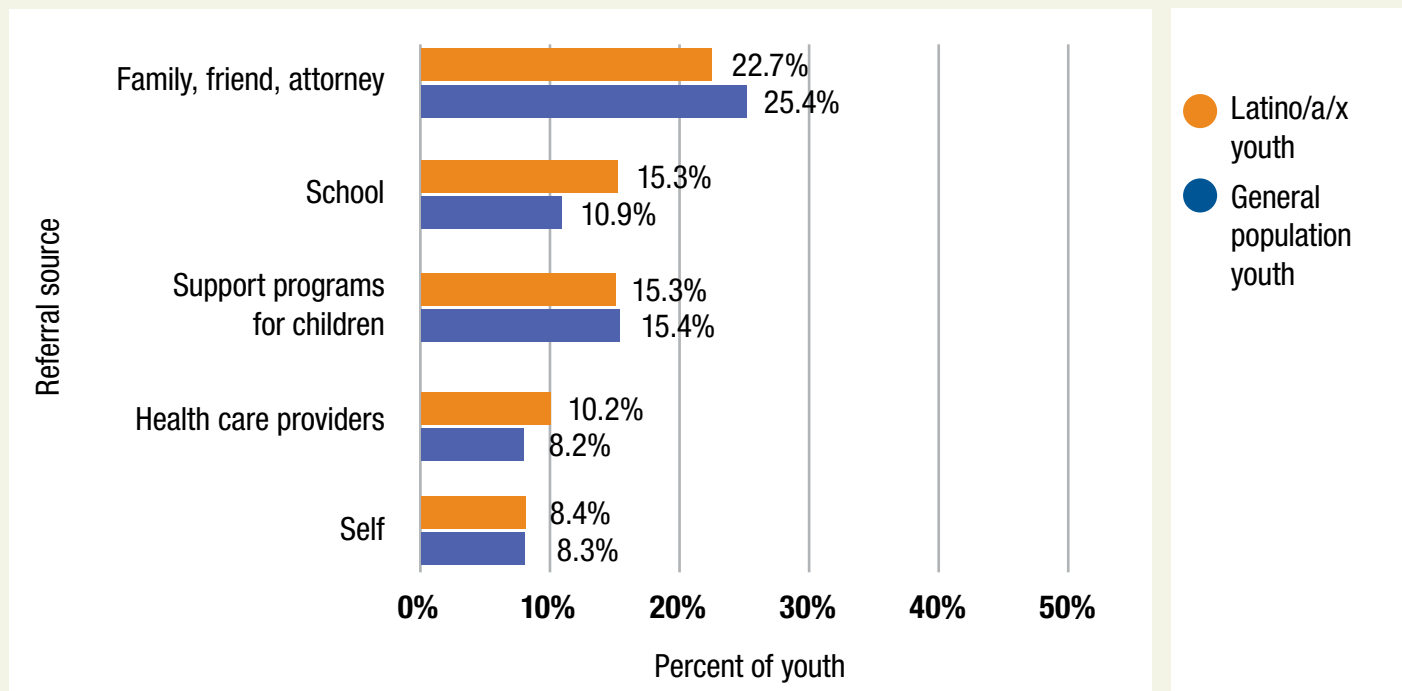
(Voelker, 2017)

Schools and youth programs are an important pathway to county mental health services for Latino/a/x youth

Family, friends, and school and other youth support programs are the most important sources of referrals to county mental health services among Oregon's Latino/a/x youth. Collectively, they make up more than half of all referrals. Compared with other groups, Latino/a/x youth are slightly more likely than other youth to be referred to county mental health services by a school, and slightly less likely to be referred by a family member or friend (Voelker, 2017).

Other research has suggested that Latino/a/x families are open to seeking care for adolescent family members, but often struggle with knowing how to access mental health services for them (García et al., 2011). This was especially true in rural areas, where only 3% of Latino/a/x parents feel they know where to take an adolescent for mental health services, compared to 18% of urban Latino/a/x parents.

Figure 20: Top referral sources* to county mental health services for Latino/a/x youth, compared to general population youth



* Referral source indicates the institution, agency or person that takes deliberate action to ensure the client is seen by a health provider. Examples include bringing the client to an appointment, writing letters and making phone calls to set up appointments.

A deliberate action is not a suggestion from someone to receive mental health care.

(Voelker, 2017)

Spotlight: Student mental health access

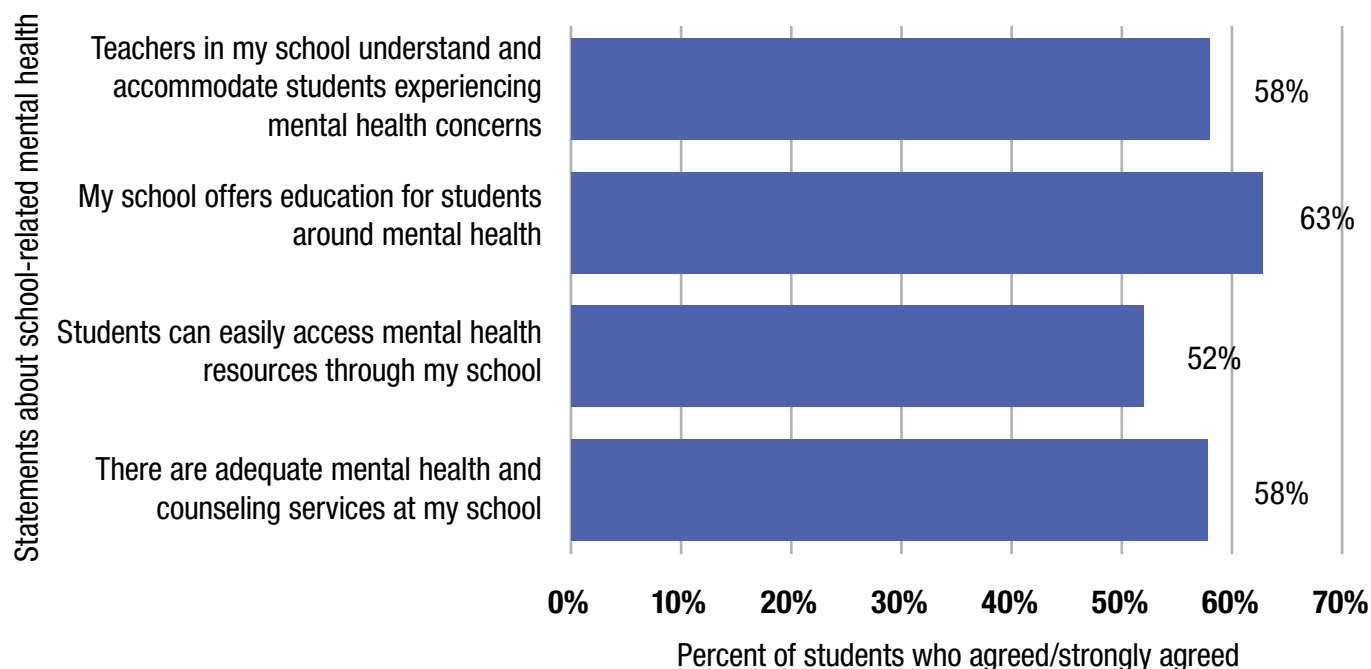
K-12 and higher education students in Oregon are increasingly calling for a greater focus on student mental health, including particular attention to supporting the mental health of students of color.

K-12

Latino/a/x students make up just less than one quarter of Oregon's K-12 students (Oregon Department of Education, 2018-2019 Fall Enrollment Report).

In a recent survey of middle and high school students, 40% reported that access to mental health resources is the most important issue that K-12 policymakers are currently considering (defined as the resources provided to support students struggling with anxiety, depression, loneliness and other mental health concerns in schools). 58% of students agree there are services for mental health available at their school, and only 52% agree that students can easily access mental health resources through their school.

Figure 21: Percent of students who agreed or strongly agreed with the following statements (n=546)



(Oregon Student Voice – State of Our Schools, 2018)

Oregon’s Joint Committee on Student Success also traveled the state conducting listening sessions that culminated in a report to the Oregon Legislature in January 2019.

Sen. Lew Frederick, a member of the committee, shared that many students spoke with him about classmates who attempted or were successful in committing suicide.

Service data and research support these first-person accounts and underscore the importance of schools as a key setting where care is accessed.

“Students are facing severe challenges outside of the classroom and need a stronger network of mental and physical health supports to be able to learn while they are in school.”

– Sen. Lew Frederick

Higher education

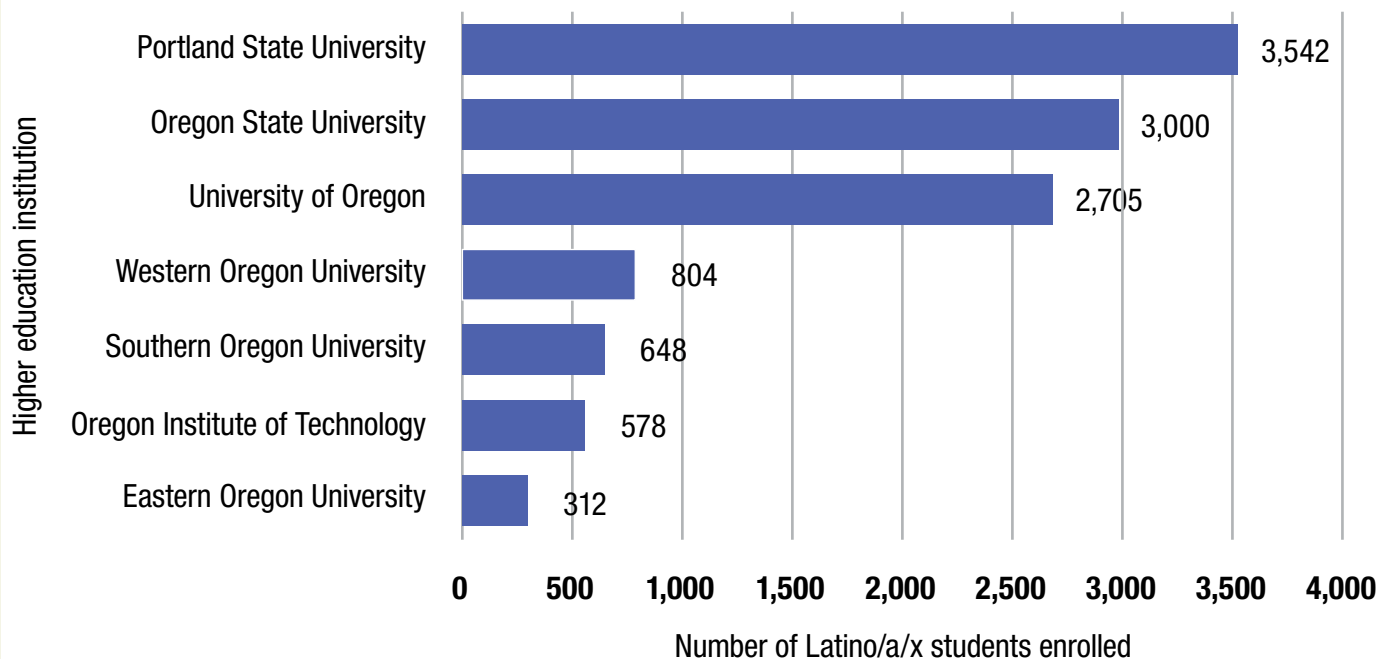
Nationally, there is a rising trend of students entering higher education with identified mental health concerns. The reported severity of these concerns is also on the rise (Gallagher, 2011; Locke et al., 2012).

In 2017, Oregon created a Student Mental Health Task Force charged with “investigating the extent to which mental health and substance use disorders have an impact on retention, recruitment and graduation rates in Oregon’s public higher education institutes.” The task force found that less than one quarter of Oregon’s public higher education institutions systematically screen their students for mental health needs. Data provided by Oregon State University reveal that 27% of students have depression or a mood disorder, while 25% suffer from anxiety disorder and 13% had experienced suicidal ideation in the previous 12 months.

Four-year universities

The share of Latino/a/x students enrolled in Oregon’s public four-year higher education institutes has increased from 4.7% in 2009 to 11.5% in 2018. The largest number of Latinos/as/x in Oregon attend Portland State University followed by Oregon State University.

Figure 22: Latino/a/x enrollment in Oregon higher education institutions



(Oregon Public University Enrollment by Race/Ethnicity, Fall 2018 Higher Education Coordinating Commission)



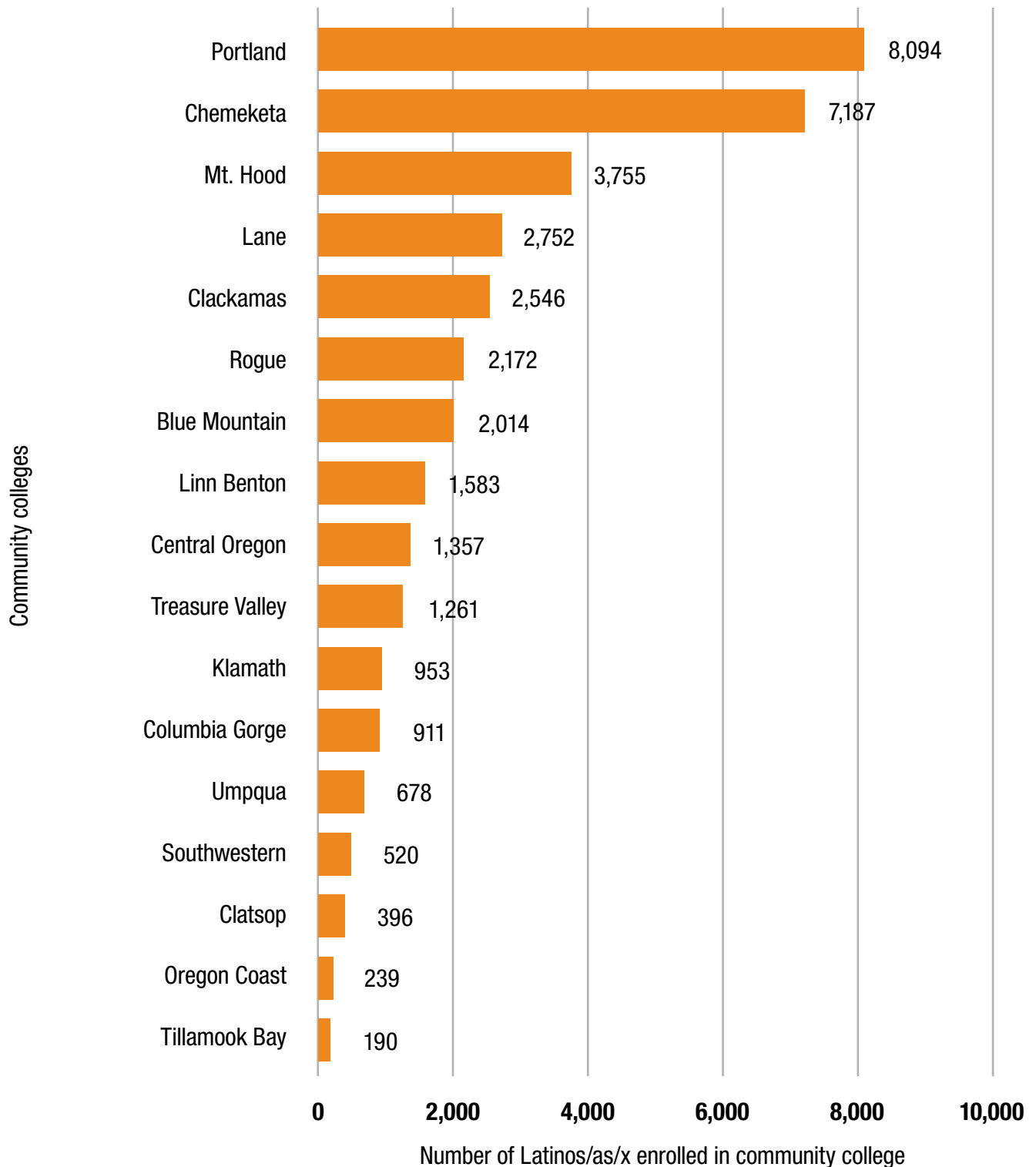
Community colleges

Latino/a/x students in Oregon are more likely to be enrolled in community colleges than four-year universities. Oregon's community colleges served 35,877 Latino/a/x students in 2018 compared to 11,589 Latino/a/x students at four-year public universities.

Latino/a/x enrollment in Oregon community colleges is geographically similar to four-year universities, with Portland Community College and Chemeketa Community College (Salem) serving roughly half of all Latino/a/x community college students in the state.

The task force found that Oregon's community colleges offer fewer mental health and substance use services, and students were less likely to perceive these programs as effective. In focus groups, students reflected that school counselors in Oregon's higher education settings rarely reflected the demographics of the students they were supporting.

Figure 23: Latino/a/x enrollment in Oregon community colleges, 2018



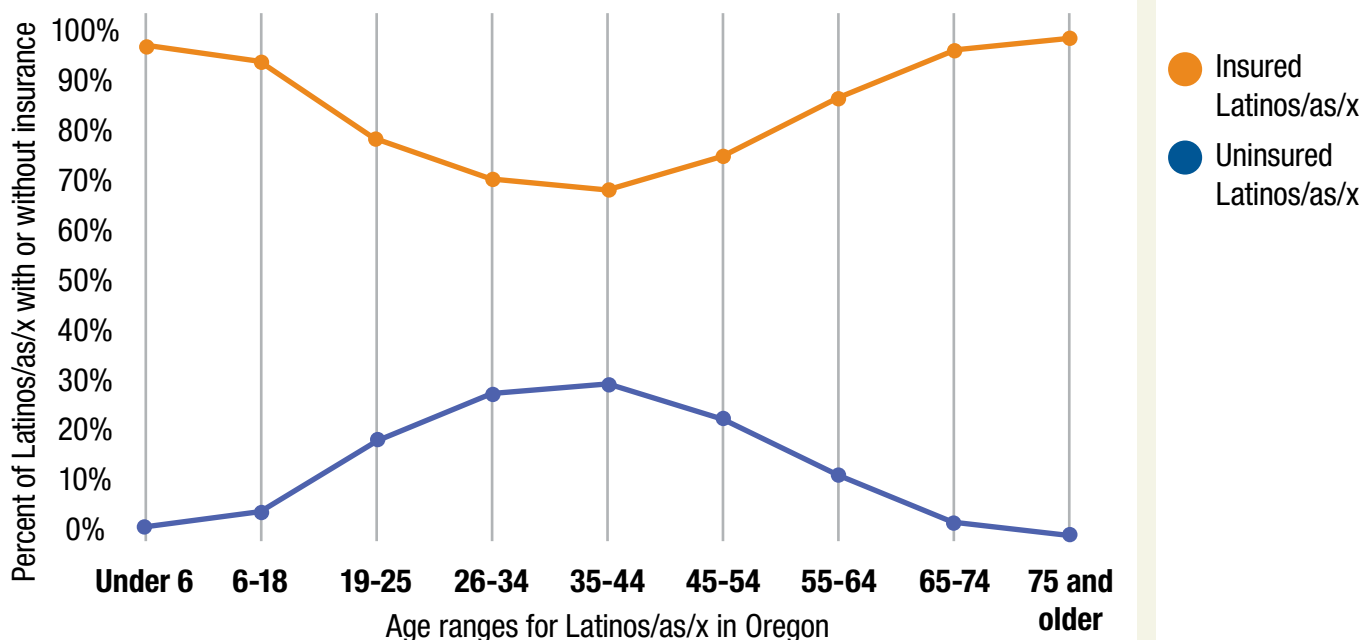
(Oregon Public University Enrollment by Race/Ethnicity, Fall 2018 Higher Education Coordinating Commission)

Disparities in mental health access persist between Latinos/as/x in Oregon and other groups, despite insurance coverage


Lack of health insurance is a barrier for Latinos/as/x in accessing mental health services, along with lack of transportation and facility locations (Guarnaccia et al., 2005). Having health insurance increases the likelihood that Latinos/as/x (and non-Latinos/as/x) receive adequate care (Alexandre et al., 2009). In Oregon, having health insurance was also predictive of health care use for Oregon Latinos/as/x who are farmworkers (López-Cevallos et al., 2012).

The percentage of Latinos/as/x in Oregon who lack health insurance has declined in recent years, from 25% in 2015 to 20% in 2017 (U.S. Census Bureau, 2017). However, these rates compare poorly with the uninsured rate for Oregon overall (8.8%) and for the non-Latino/a/x white population (7.1%) (U.S. Census Bureau, 2017). Those who are foreign-born (of any race) are also uninsured at much higher rates in Oregon than the native-born population (23% versus 7%) (U.S. Census Bureau, 2017). Latinos/as/x in Oregon are also most likely to be uninsured during their working and child-bearing years, while rates of insurance coverage are higher in younger and elderly adults (U.S. Census Bureau, 2017).

Figure 24: Latinos/as/x in Oregon are most likely to be uninsured during middle age



(U.S. Census Bureau, 2017)



While insurance coverage is positively associated with accessing mental health services, gaps remain. Latinos/as/x with insurance are still less likely than their white counterparts to access mental health services; a 2012 state audit of the Medicaid-funded Oregon Health Plan showed that Latinos/as/x were accessing mental health services at a disproportionately low rate; however, the reason for this is not clear. The low rate is not explained by a lower need for services. (St. Amour, 2017). Other research has also found that Latinos/as/x with private health insurance are less likely to seek outpatient mental health services than their non-Latino/a/x white counterparts (Thomas et al., 2001).

Fear of seeking services due to residence status

Interviews with providers suggest fear of accessing mental health services is especially acute among Latino/a/x immigrants, particularly those without documentation of their immigration status.

There is a widespread perception that a hostile political climate and the policies of the Trump administration have led Latinos/as/x to avoid seeking mental health services, particularly services provided through local and state government agencies. Fear of detention and deportation is not only a barrier to accessing mental health care, but a source of significant anxiety and distress.

“ *Access is related to residence status.*”

– Mental health provider,
Oregon (St. Amour, 2017)

“ *We have seen a lot of fear [since the election] and the numbers of Latino/a/x clients has dropped significantly. I get a lot of questions about whether I will be reporting them and what I am writing on the forms... there is a lot of mistrust and worry about coming in for mental health care.*”

– Mental health provider,
Oregon (St. Amour, 2017)

“ *Latino/a/x clients are less likely to seek out government-provided mental health services because they are worried about Immigration and Customs Enforcement.*”

– Program Coordinator,
Oregon (St. Amour, 2017)

Known barriers to accessing mental health care

Mental health services are still stigmatized and not well integrated in places where Latinos/as/x engage with other services



Hernandez, William. (n.d.). Mural for El Dia de los Muertos/Altar para Diego Rivera. Reprinted with permission.

Accessing mental health services is stigmatized in Latino/a/x communities. This is also true in other communities. Individuals may fear being labeled crazy or “loco” if it is known that they have sought mental health treatment (Honda, 1996). In a survey of Latino/a/x adults ages 55+, feeling uncomfortable talking to a professional or wanting to handle a mental health problem on their own were reasons cited for not seeking treatment (Sorkin et al., 2016).

Interviews with providers in Oregon suggest that raising awareness and knowledge about

mental health conditions in Latino/a/x communities will require attention to culturally appropriate outreach, such as the use of stories and fotonovellas (short graphic novels) and greater reliance on trusted sources such as peer support workers who are members of the community (Human Services Resource Institute, 2018).

Mental health services are also not well integrated in places where Latinos/as/x access other services, such as schools and school-based health centers, housing, and churches. Providers note that integrating these services in preferred places is an opportunity to reduce stigma and improve access in Oregon,

“ We can’t just hand out pamphlets and expect Latinos/as/x individuals to show up for services.”

– Mental Health Provider, Oregon (St. Amour, 2017)

particularly for those individuals with complex needs that may span mental health, physical health and/or social support (St. Amour, 2017; Human Services Resource Institute, 2018).

Given the importance of spirituality and religion for this population, providers have also noted that many Latinos/as/x may be better served by integrating *curanderos* (spiritual healers), priests and church staff into mental health care and using an approach that more holistically blends mental health considerations with spiritual and emotional well-being (St. Amour, 2017).

“*The church is a good place for Latinos/as/x to come. People have trust and it is a source of community and probably a good place to access mental health care. We somehow need to bridge the gap between the church and mental health providers.*”

— Church Administrator,
Portland (St. Amour, 2017)

Mainstream mental health services are often not culturally or linguistically inclusive for Latinos/as/x in Oregon




In 2019, the Oregon Psychiatric Physicians Association recognized Commissioner Meieran with the Henry J. Grass Access Award in recognition of her advocacy to improve Oregon's mental health system. Retrieved November 9, 2020 from https://multco.us/sites/default/files/styles/medium/public/33373293748_77365c0927_o.jpg?itok=IJuLW5Kq.

Latinos/as/x in Oregon may face challenges accessing and using services when information is not available in Spanish or other indigenous languages spoken by Latinos/as/x, or when translation and interpreter services are not available.

Many of Oregon's contracted county mental health agencies do not have information on their websites in languages other than English. These websites may also not include instructions for getting help in languages other than English, including information on how to access mental health crisis services. Fewer still have information about the availability of culturally responsive services or bicultural providers.

Oregon's coordinated care organizations (CCOs) are required to make linguistically or culturally responsive services available to patients. They also must work together with their contracted providers to develop best practices of culturally and linguistically appropriate care (Oregon Administrative Rules, 410-141-3015 and 410-141-3145). However, these services or resources



may only be available upon request. In addition, information on how to access linguistically or culturally appropriate services may be unclear or unavailable. For example, prescription medication labeling is not always available in languages other than English.

Lack of bilingual and Spanish-speaking services impedes the experiences of Latinos/as/x in Oregon who do access services (Fripp & Carlson, 2017). Research suggests that having a health care provider that does not speak a patient's primary language is directly associated with poor health outcomes, health disparities and lower patient understanding about their health status and conditions (Sanchez et al., 2015).

Currently, 20% of Oregon's health workforce is bilingual (a greater share than the population as a whole), including approximately 10% of the workforce that speaks Spanish (Oregon Health Authority, 2017). However, this does not guarantee that bilingual providers are available and located in the regions where Spanish-speaking patients need them. Seventy-five percent of Oregon's bilingual health care workforce is located in just six counties: Clackamas, Jackson, Lane, Marion, Multnomah and Washington.

Providers have noted the importance of not only having bilingual mental health service providers, but bilingual staff at all points of care engagement, from the time an individual presents at a clinic to the ongoing advocacy and support patients need following treatment (St. Amour, 2017). Nurse practitioners, physicians'

“*The experience of accessing mental health services through a translator really impacts the accessibility of the services. Many choose to not even start services, or if they do try it, they will only go once or twice and then disengage.*”

– Mental Health Provider,
Oregon (Honda, 2019)

“*I have to lean more on my culture to understand how to talk to elders, what kinds of words are triggering. We don't use the word 'anxiety'. It does not make sense to families.*”

– Mental Health Provider
(Honda, 2019)

“*Ask the client what values are important to them and if spirituality is important, try to incorporate spirituality into their treatment.*”

– Mental Health Provider,
Oregon (Honda, 2019)



assistants and physicians are the most likely to speak Spanish (18%, 16%, and 16% respectively), while clinical nurse specialists are the least likely (1%) (Oregon Health Authority, 2017).

Providers also note there is much more to providing culturally responsive services than simply being able to converse in Spanish (HSRI, 2018; Honda, 1996). There are differences in nonverbal norms such as eye contact and verbal communication style between Latinos/as/x and non-Latinos/as/x. These differences can lead to misunderstandings even when a provider is bilingual (Guarnero, 2005). Certain words and phrases do not directly translate and can lead to confusion and misdiagnosing.

Spotlight: OHSU's Intercultural Psychiatric Program

There are few culturally responsive programs available in Oregon for psychiatric care. One exception is [Oregon Health & Science University's Intercultural Psychiatric Program \(IPP\)](#) that has provided culturally sensitive mental health services since 1977 to immigrant, refugee and ethnic communities with an emphasis on individuals and families whose first language is not English. Many patients have fled their home countries due to the impact of war, violence, displacement and political and economic upheaval.

The IPP has been recognized nationally as one of the oldest culturally responsive psychiatric programs in the country. In addition to the OHSU program, Pacific University offers [Sabiduría](#), a Latino/a/x track in their PsyD program as well as their MSW program.

Mental health providers report a “disconnect” between mainstream mental health treatment practices and what works for Latino/a/x patients, and that evidence-based practices and screening questions that have been tested for white populations often don't translate for the Latino/a/x population (Honda, 1996). Effective assessment for historically underserved populations entails customized collection of a variety of cultural information and data, interpretation of these data to formulate a working hypothesis, and the incorporation of these cultural data with other relevant clinical information to test the working hypothesis. This assessment, grounded in culture and sensitive to data collection that can be collected in diverse modes (e.g., oral; cultural research and learning; and, clinical), leads to effective evaluation that fits the client (Ridley et al, 2008).

When Latinos/as/x are asked about their preferences in mental health care delivery, oral themes such as listening, understanding and managing differences are similar to non-Latino/a/x whites and African Americans. However, deeper exploration finds that these terms don't mean the same thing to these groups. Latinos/as/x may have different (longer) expectations for the amount of time it takes to adequately discuss and understand their mental health concerns, compared to non-Latino/a/x

whites. Latinos/as/x more highly value *profundizar* (going deeper) beyond what is superficially said or seen (Mulvaney-Day et al., 2011).

Such instances of misalignment between mainstream practices and culturally specific practice that upholds a quality-of-care framework are the manifestations of an overall system that requires systemic change. This change must be rooted in the experiences of historically underserved populations to inform how the structures, processes and outcomes in the behavioral health system affects direct service to individual clients (Abe-Kim, Takeuchi, 1996).




Hernandez, Hector. (2011). *Dreaming of Educational Horizons*. [Acrylic on canvas]. La Casa Latina, Portland State University. Portland, OR. Reprinted with permission.

Many Latinos/as/x in Oregon experience racism and discrimination from providers and report fear and mistrust of the health care system

The lower rates at which Latino/a/x people access mental health services may be partly explained by widespread experiences of discrimination. Research in Oregon found four in 10 Latinos/as/x living in rural Oregon have experienced discrimination in health care, including 45% of foreign-born and 32% of U.S.-born Latinos/as/x (López-Cevallos et al., 2014). This discrimination and related mistrust of health professionals are also drivers of young adult Latino/a/x population's lower satisfaction with the health care system in Oregon (López-Cevallos et al., 2014).

Data from the Behavioral Risk Factor Surveillance System, which has collected information about modifiable risk factors for chronic diseases and other leading causes of death from 2011 to the present among adult Medicaid members, note that 7.5% of Latinos/as/x communities in Oregon felt their own experiences with health care in the past year were worse than for other races (compared to 6.4% statewide). In Latino/a/x Medicaid members, 9.2% also experienced



emotional symptoms in the past 30 days due to how they were treated based on their race or ethnicity (compared to 7.5% statewide) (Oregon Health Authority, Medicaid Behavioral Risk Factor Surveillance System).

Providers have called for trauma-informed models of care. However, an assessment of Multnomah County's mental health system found that even within a self-described "trauma-informed" system, patients sometimes report experiencing the exact problems that a trauma-informed approach aims to prevent. These include providers who lack empathy and don't acknowledge their own biases (particularly regarding race) as well as overt threats such as reliance on physical force and restraint of patients (Human Services Resource Institute, 2018).

“People in the Latino/a/x communities can't live under such fear and stress and not be impacted in the long term. I am specifically thinking of kids and the lasting trauma.”

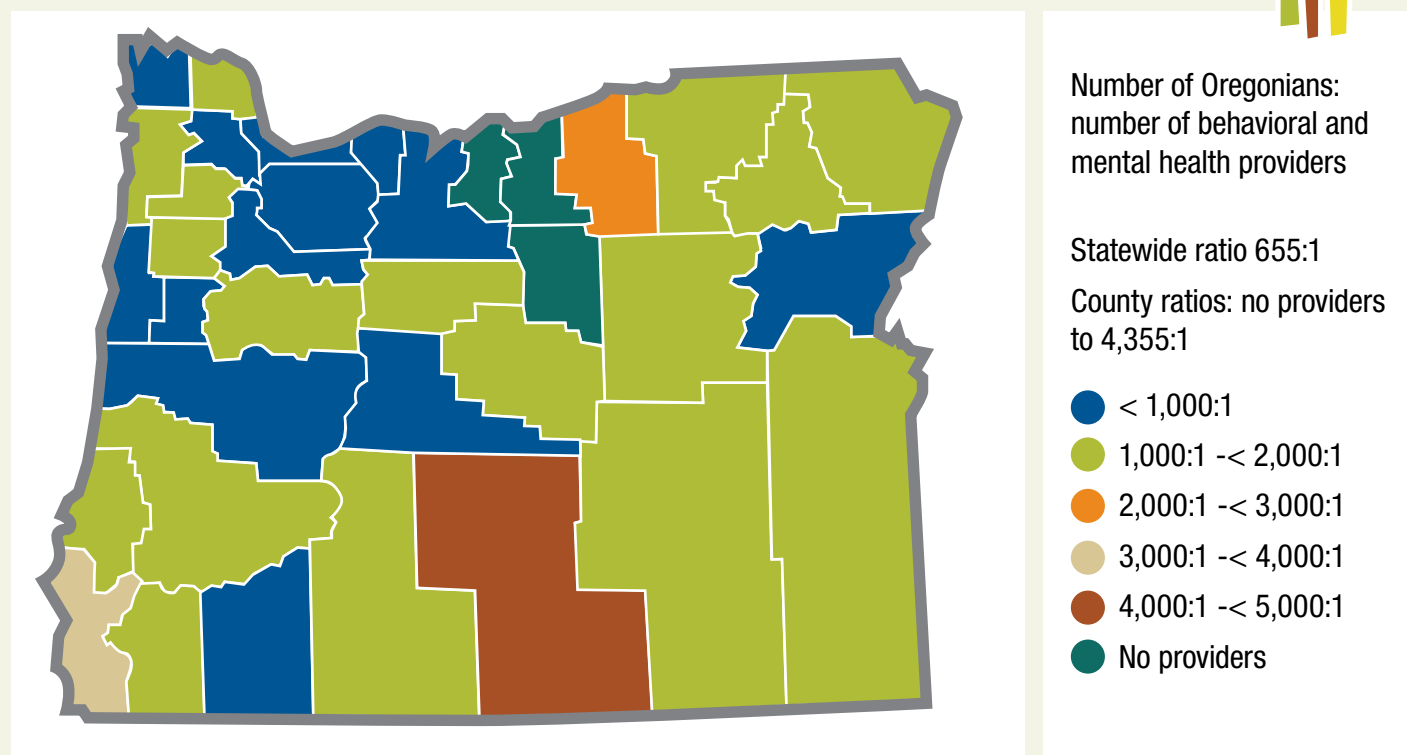
— Mental Health Provider,
Oregon (St. Amour, 2017)

Workforce challenges

There is a shortage of mental health professionals in Oregon

Oregon has one full-time licensed behavioral or mental health provider for every 655 people statewide (Oregon Health Authority, Healthcare Workforce Reporting). While this rate overall compares favorably to the national average of mental health providers in the National Provider Index (NPI) (1:310) (University of Wisconsin Population Health Institute, 2019), it masks extreme variation at the county and local level. For example, Polk County has one full-time licensed behavioral or mental health provider for every 350 residents while Sherman, Wheeler and Gilliam counties have no full-time licensed behavioral or mental health providers (Oregon Health Authority, Healthcare Workforce Reporting).

Figure 25: Behavioral and mental health provider density in Oregon, 2020



Lower number indicates more behavioral and mental health providers per resident.

Behavioral and mental health professionals include all psychologists, counselors and therapists, licensed clinical social workers, and clinical social work associates; physicians and physician assistants who specialize in psychiatry (addiction, neurology, child, adolescent, geriatric or forensic) or psychoanalysis; nurse practitioners who specialize in psychiatry/mental health; and naturopathic physicians who specialize in mental health.

(Health Care Workforce Reporting Program, Oregon Health Authority)

<https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Health-Care-Workforce-Reporting.aspx>

In rural areas, the mental health workforce shortage is even more dire, disproportionately affecting Latinos/as/x

There are also a number of designated health professional shortage areas (HPSAs) specifically for mental health in Oregon, including certain coastal communities and Central Oregon [see Appendix 4 for Oregon health professional shortage area (HPSA) designated areas]. More than half of mental health clinicians with prescription authority are located in the Portland Metro region, as are half of all registered nurses who work in mental health settings (Oregon Health Authority, 2015).

Patients must often travel farther to access mental health services in rural areas, and lack of transportation and childcare, and limited availability of evening hours are cited as challenges for Latinos/as/x aiming to access mental health services in rural Oregon (St. Amour, 2017; Hernandez, 2018).



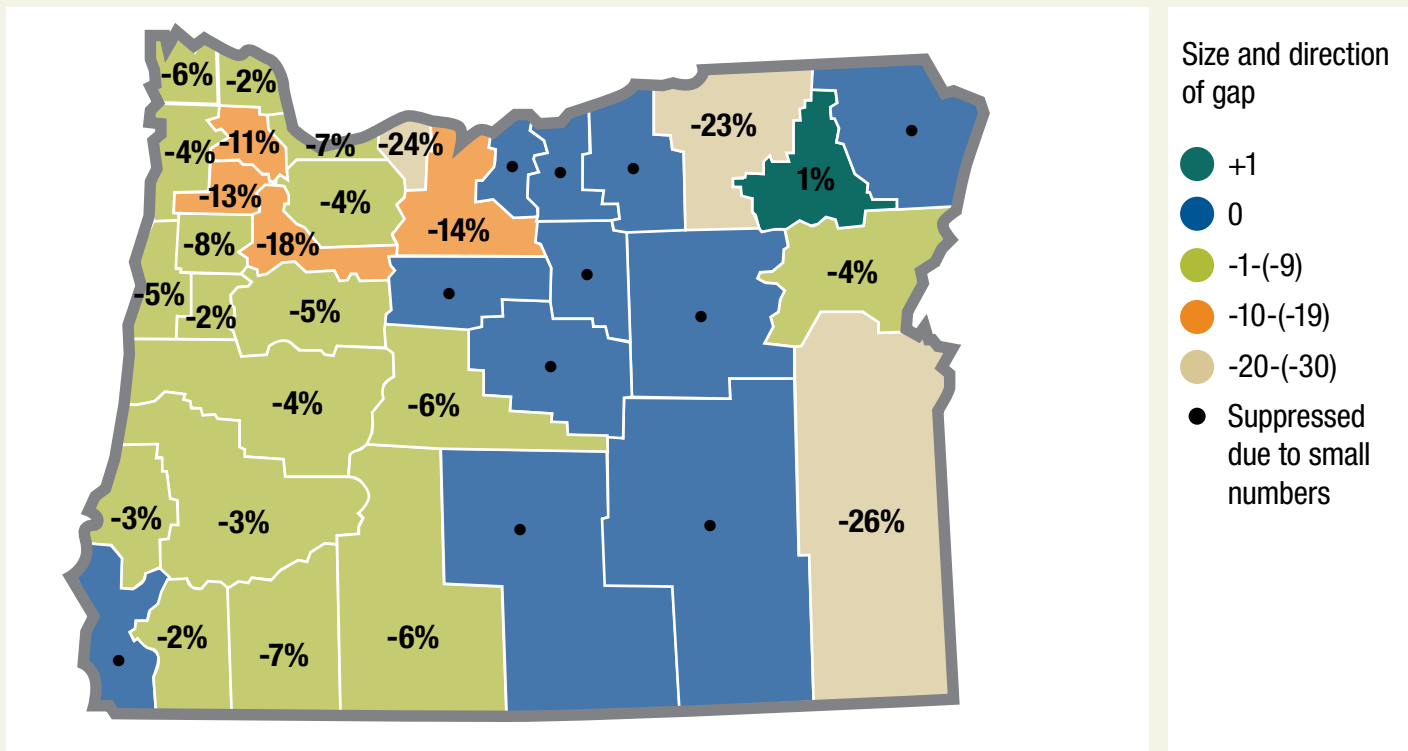
Table 2: Ratio of population to behavioral and mental health providers in Oregon counties with the largest proportion of Latino/a/x residents (Hernandez, 2018)

County	Proportion of Latino/a/x residents (University of Wisconsin Population Health Institute, 2019)	Ratio of full-time licensed behavioral and mental health providers to residents (Oregon Health Authority 2017)	Ratio of behavioral and mental health providers, identified by NPI numbers*, to residents (University of Wisconsin Population Health Institute, 2019)
Morrow	36.3%	2818:1	130:1
Malheur	33.1%	1223:1	200:1
Hood River	31.3%	710:1	290:1
Umatilla	26.4%	1705:1	260:1
Marion	26.2%	712:1	290:1

* These data come from the National Provider Identification (NPI) data file, which has some benefits and limitations. Providers who transmit electronic health records are required to obtain an NPI. A benefit of utilizing NPIs to identify behavioral and mental health providers is that NPIs capture mental health and behavioral health providers that are not licensed and not full time, likely also capturing providers that are community-based and diverse. Limitations include the following: (1) Providers who serve a small number of clients may not obtain a number; (2) While providers have the option of deactivating their identification number, some mental health and behavioral health providers included in this list may no longer be practicing or accepting new patients. This may result in an overestimate of active mental health and behavioral professionals in some communities; and, (3) It is also true that mental health providers may be registered with an address in one county, while practicing in another county. <https://www.countyhealthrankings.org/app/oregon/2018/measure/factors/56/data>.

The difference in numbers of licensed behavioral and mental health providers in contrast to behavioral and mental health providers identified by NPI numbers points to the likelihood that many unlicensed providers may work in community-based organizations and provide culturally and linguistically specific services; these unlicensed providers be untapped resources for providing services that can support Latinos/as/x in Oregon.

Figure 26: Gap in Latino/a/x licensed behavioral and mental health care professionals* compared with county populations



A negative value means that the percentage of health professionals who identify as Latino/a/x is smaller compared with the Latino/a/x populations. For example, 33% of Malheur county's population identify as Latino/a/x, while only 7% of the county's health care workforce identify as Latino/a/x – a gap of 26%.

Data are from the 2020 Health Care Reporting Program database

*Data include providers that held an active license as of January 2020.

(Oregon Health Authority, Oregon Health Care Workforce Reporting, 2020 database. Prepared by: Vanessa Wilson)

Availability of facilities such as school-based health centers, as well as culturally specific programs and services, also varies by community and county across Oregon. Culturally specific specialty services, such as psychiatric care or resident drug and alcohol treatment programs, are especially rare or non-existent in many counties across Oregon.

This shortage of culturally specific services is additionally troubling because some providers report that Latinos/as/x may be reluctant to access mental health services if they are concerned about "everyone knowing your business" in a small community (Human Services Resource Institute, 2018).

Spotlight: BestCare

BestCare offers mental health and addiction treatment services in multiple locations across Central and Southern Oregon, including operating one of the only Latino/a/x residential programs in the state and the only CARF-certified program in the Northwest (BestCare, n.d.).

Oregon's health care workforce does not reflect the population it serves, and there is a shortage of bilingual and bicultural mental health professionals

The licensed health care workforce in Oregon is less racially and ethnically diverse than the population it serves, and Latinos/as/x are underrepresented as a whole, with 4.7% of the health care workforce identifying as Latino/a/x compared with 12.8% of the Oregon population.

There is even more of a disparity within the licensed mental health workforce: Only 3% of the mental health workforce identified as Latino/a/x, significantly lower than Oregon's population (Oregon Health Authority, 2015).

Despite the importance of culturally appropriate care, interviews with Oregon providers and community listening sessions reveal a severe shortage of culturally specific services, particularly services for children and youth, and acute or crisis services



DeSiga, Daniel. (n.d.). Woman farmworker in a field. Reprinted with permission.

“[There are] no culturally specific services for Latino/a/x individuals, no bilingual providers, and interpreters are often used in a crisis situation and this really doesn't work well and creates barriers.”

— Mental Health Provider,
Oregon psychiatric hospital (St. Amour, 2017)



(St. Amour, 2017; Human Services Resource Institute, 2018).

Bilingual and bicultural mental health providers report long waitlists for their services, requiring them to often refer patients to non-culturally specific providers (Honda, 1996).

The need for a more culturally diverse and bilingual health care workforce has been cited as a critical need in Oregon (St. Amour, 2017; Hernandez, 2018). Traditional health workers — including community health workers, peer support and peer wellness specialists, patient navigators and doulas — provide opportunity to develop a more racially and ethnically diverse workforce over time (Oregon Health Authority, 2017).

Training and credentialing programs do not prioritize recruitment from Latino/a/x communities or define clear career paths

While there is clear need to recruit and train more mental health professionals from Latino/a/x communities, interviews with providers reveal perceptions that Oregon lacks a long-term plan for developing a more racially and ethnically diverse workforce (St. Amour, 2017). There are particular challenges noted in recruiting and training masters and PhD level professionals.

Community stakeholders have expressed the need for a more comprehensive workforce strategy that would include coordination among state and local agencies, and mental health service organizations and schools, in order to develop more clearly defined career pathways for bilingual and bicultural students, beginning in high school and advancing through graduate level training.


Stakeholders described pathways that would include clear advancement opportunities and mechanisms, and financial assistance and scholarships, particularly earmarked for rural community placements (St. Amour, 2017; Hernandez, 2018). Traditional health worker programs were also

“*There are so many people that want the service that we can't serve them. There is a long waitlist and not a lot of options.*”

— Mental Health Provider,
culturally specific mental health clinic,
Oregon (St. Amour, 2017)

“*We need advanced degree professionals or we risk creating a system of second tier services.*”

— Program Manager,
Rural Oregon (St. Amour, 2017)



identified as an entry point to mental health careers that could be deliberately developed to recruit and train additional Latino/a/x mental health professionals (St. Amour, 2017).

J1 Visa programs, where international graduates complete residencies in the United States and then work for limited durations in health care shortage areas, have also been proposed as a short-term solution that could bolster the rural mental and behavioral health workforce (Hernandez, 2018). While this idea is a potential solution, several factors contribute to it being limited in potential. Eighty percent of these

slots granted to Oregon each year are reserved for primary care physicians by Oregon law, which limits the degree to which this program could be used to recruit mental and behavioral health professionals (Stock et al., 2017). The placements that do occur are unlikely to result in long-term workforce development in rural areas because the numbers of mental and behavioral health professionals using this program are limited; 12 psychiatrists have been practicing in Oregon since 2002 in this program (Conrad State 30 and Physician Access Reauthorization Act; M. Overbeck, personal communication, October 13, 2020). Also, sometimes placements do not result in good provider-community fit (University of Wisconsin Population Health Institute, 2019), perhaps in part because only a small minority of the 12 psychiatrists in this program are Latino/a/x culturally specific providers, and without deep cultural competence, mental health care can be riddled with misalignment that affects the therapeutic alliance in care and the prescribing of medications (Reyes et al, 2004).

“A few years ago in our rural area we chose to train community health workers to increase access for Latinos/as/x and it allowed us to knock down many barriers. It was culturally responsive and it helped greatly.”

– Executive Director,
Oregon (St. Amour, 2017)

There is no clear process for re-credentialing or transferring licenses of Latino/a/x immigrants with existing training

Oregon’s credentialing process for mental health professionals allows for a combination of education, certification and experience, but lacks a robust process for transferring licenses or recertifying advanced mental health professionals from other countries (Oregon Commission on Hispanic Affairs Policy Work Group, October 2018 minutes). There is also currently no strategy for recruiting advanced mental health professionals from Spanish-speaking countries to become licensed mental health providers in Oregon. These possible opportunities were identified by mental health professionals in Oregon as a potential strategy for recruiting a bilingual and bicultural workforce (St. Amour, 2017; Honda, 1996; Hernandez, 2018).



Oregon's mental health system does not adequately pay for or support the professional development of culturally specific mental health providers

Professionals in Oregon's mental health system report low pay, inadequate support and training, and heavy workloads that compromise their ability to provide quality care (HSRI, 2018). This is especially true for direct support workers, whose low wages are sometimes inadequate to cover the cost of housing in the communities where they work.

In the Portland Metro area, an estimated 27% of community and social service workers had median wages below the living wage for a family of four with two working adults (AFSCME Council 75, 2017). Providers also report few options to help repay their student loans (HSRI, 2018). These statistics have equity implications for the recruitment of mental health professionals from Latino/a/x communities; Latinos/as/x in Oregon are already disproportionately affected by poverty as well as economic and housing insecurity in Oregon (Flores, 2019).

Community-based mental health service organizations report it is difficult to retain mental health staff because county agencies, large health systems and health plans offer more competitive salaries, leading to employee turnover as high as 40–60 percent each year (HSRI, 2018). Additionally, interviews revealed that some bilingual and bicultural providers perceive they are passed over for promotions because their organizations cannot afford to lose them in direct service roles, while others have noted that leadership opportunities for clinicians can help them stay engaged and committed to their work (Human Services Resource Institute, 2018; Honda, 1996).

Mental health work environments do not account for cultural complexity in provider caseload or supervision, and thereby contribute to inequitable workloads and provider burnout

Providing culturally specific mental health care requires management of cultural complexity, which needs intensive case management and significant additional time per client for culturally specific providers (Tummala-Narra, 2016). Managing cultural complexity requires the following additional skills, knowledge and labor:

- It often requires extensive psycho-social education and extra information and resources to pre-counsel clients on mental health counseling benefits and counter deeply held concerns about the stigma associated with receiving mental health care.



- Bidirectional translation and interpretation is when culturally specific mental health practitioners provide translation, interpretation and grounding in the perspective and language of their clients. They also provide translation, interpretation and grounding for their supervisors who are typically mainstream practitioners without the extensive training in cultural competency needed to supervise culturally specific mental health providers well.
- The counselor needs ongoing consideration, learning and research to meet high standards of cultural competency on topics with which they may or may not be familiar. Examples of these topics could include specific ethnic group histories and practices, as well as current cultural challenges Latinos/as/x face in their daily lives, such as child-parent separation at the U.S. border, being essential workers during a pandemic, and the disproportionate impact of sickness and death from COVID-19.

Since cultural complexity is a critical aspect of providing culturally specific care, culturally specific providers are also often asked to consult on or provide translation and support to their mainstream coworkers for Latino/a/x patients, or to take on extra clients, over and above their own already heavy workloads.


Scaling of caseloads for culturally specific caseloads downward to account for cultural complexity* is, therefore, essential to address these inequities and enable culturally specific providers to provide high quality mental health care that is a good fit for clients, and to prevent mental health provider burnout. Such scaling also requires increased resources and additional infrastructure.

There is also a need for education programs and workplaces to better prepare to support bilingual and bicultural mental health professionals. Latino/a/x peer support and community health workers who are recruited for their ability to better engage with patients sometimes report their lived experiences are devalued and their work delegitimized by clinicians and health system administrators (Human Services Research Institute, 2018).

Interviews with bilingual and bicultural mental health professionals in Oregon suggest some higher education institutes alienate Latino/a/x students, and their workplaces often did not engage in diversity, equity and inclusion training.

While it is not essential that a competent culturally specific provider or supervisor be a person of color, it is essential for culturally specific providers or supervisors to have extensive training in

* In scaling caseloads downward, every mental health work environment would be best served by conducting its own review to determine the extent of scaling needed. As an example of possible scaling down, some agencies have reduced caseload from one provider for 75 clients to one provider for 35 clients to account for cultural complexity.



cultural competence and lived experience for individuals of color is, for many, part of the cultivation of deep cultural competence.

Finally, bilingual and bicultural providers don't know how to find one another. They lack strong professional networks of other bilingual and bicultural mental health professionals. This lack of connection contributes to providers feeling unsupported, and unable to help individuals seeking access to other mental health providers when their own waitlists get long. There is a sense there may be other bicultural providers in the community, but they don't know where to find them.

Funding challenges

Strategies are fragmented and there is limited coordination of efforts across sectors

OCHA's conversations with community partners reveal a common thread that Oregon lacks a coordinating mechanism across agencies and commissions to better align disparate mental health efforts and resource streams. For example, rural communities have a perceived lack of coordination across state and local law enforcement agencies and mental health counselors (Oregon Commission on Hispanic Affairs Policy Work Group, October 2018 Minutes). Similarly, Oregon's coordinated care organizations are not well engaged with traditional health worker programs or higher education systems in developing Oregon's future mental health workforce.

Community partners described frustration with how funding is structured for mental health services in Oregon, describing it as "compartmentalized," "bifurcated," "a huge barrier" and "not unified" with physical health funding. Some stakeholders have noted that mental health funding still operates largely as a "carve out" from other health and social service systems (Human Services Resource Institute, 2018). Many saw a need for streamlined reimbursement processes and general operating funds to provide flexibility to develop culturally specific programs.

“*My supervisor tried to do their best to support [me], but it was hard for them to understand the [cultural complexity in my] workload as they were not a person of color.*”

– Mental Health Provider,
Oregon (Honda, 2019)

“*There are very limited resources. In my county there are only two bilingual mental health therapists. If there are others, I don't know where they are.*”

– Mental Health Provider,
Oregon (Honda, 2019)

Oregon has been working to remedy decades of neglect of the state behavioral health system. In part, this neglect has been a national story dating back to the Mental Health Systems Act of 1963 to fund community-based services and prevention. Unfortunately, across the country, communities have only enough resources to address individuals who are a danger to themselves and others, and community-based services and prevention efforts have never been fully implemented. Oregon experienced a recession in 1976 that preceded a tax revolt, which further curtailed funding of schools and perceived non-essential health services, such as mental health. State lawmakers have only had resources in the past few years to begin rectifying that gap.

Former Governor Kitzhaber began a process of revamping all state service institutions, mental health among them. Besides mental health parity, he guided the Legislature to a restructuring of the Oregon Health Authority to incorporate the previously separate mental health agency. Despite continuing to rank among the nation's lowest in terms of mental health services, funding and support for mental health began to look promising. Then came COVID-19. In 2021, with the loss of revenue, the state will be hard pressed to meet even minimal demands for mental health services.

Because of the state's inability to respond to the need for resources, the private sector — individuals, corporations and philanthropic institutions — must step up to partner with the state to meet the needs of all communities. Creation of a task force is recommended, to be composed of corporate, philanthropic and community-based organizations, along with the Oregon Advocacy Commissions. It would consider the needs of the state, our historically underserved communities and the Latino/a/x communities.



DeSiga, Daniel. (n.d.). *El Serape*. Reprinted with permission.

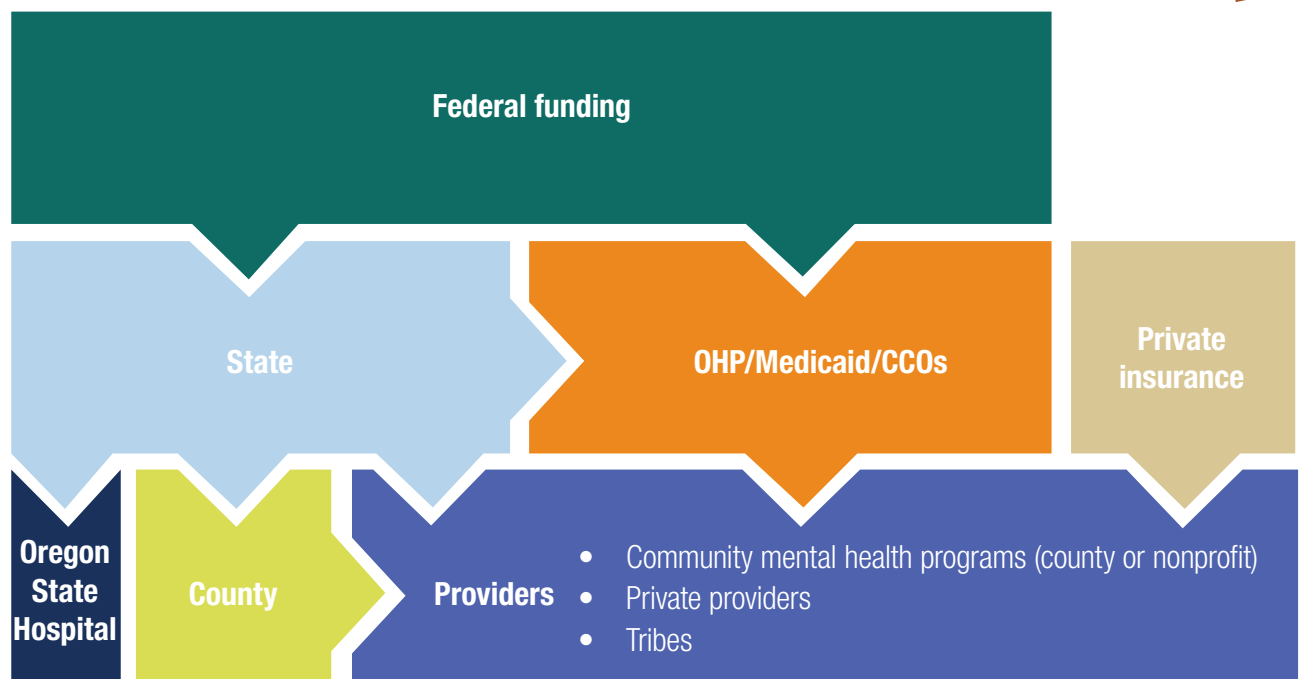
“Some of my funds are tied to diabetes treatment and I often hope that the person has diabetes so that I can also treat their mental health issue and get reimbursed. Otherwise I have to turn the individual away.”

— Program Director,
rural Oregon (St. Amour, 2017)



The figures below provide examples of the complexity of mental health funding in Oregon. Figure 27 reflects the public dollar flow of behavioral health system funding in Oregon*, and Figure 28 reflects the public dollar flow of mental health funding in Multnomah County.

Figure 27: Behavioral health funding streams for Oregon



(Oregon Health Authority: Behavioral Health Services Program, 2020)

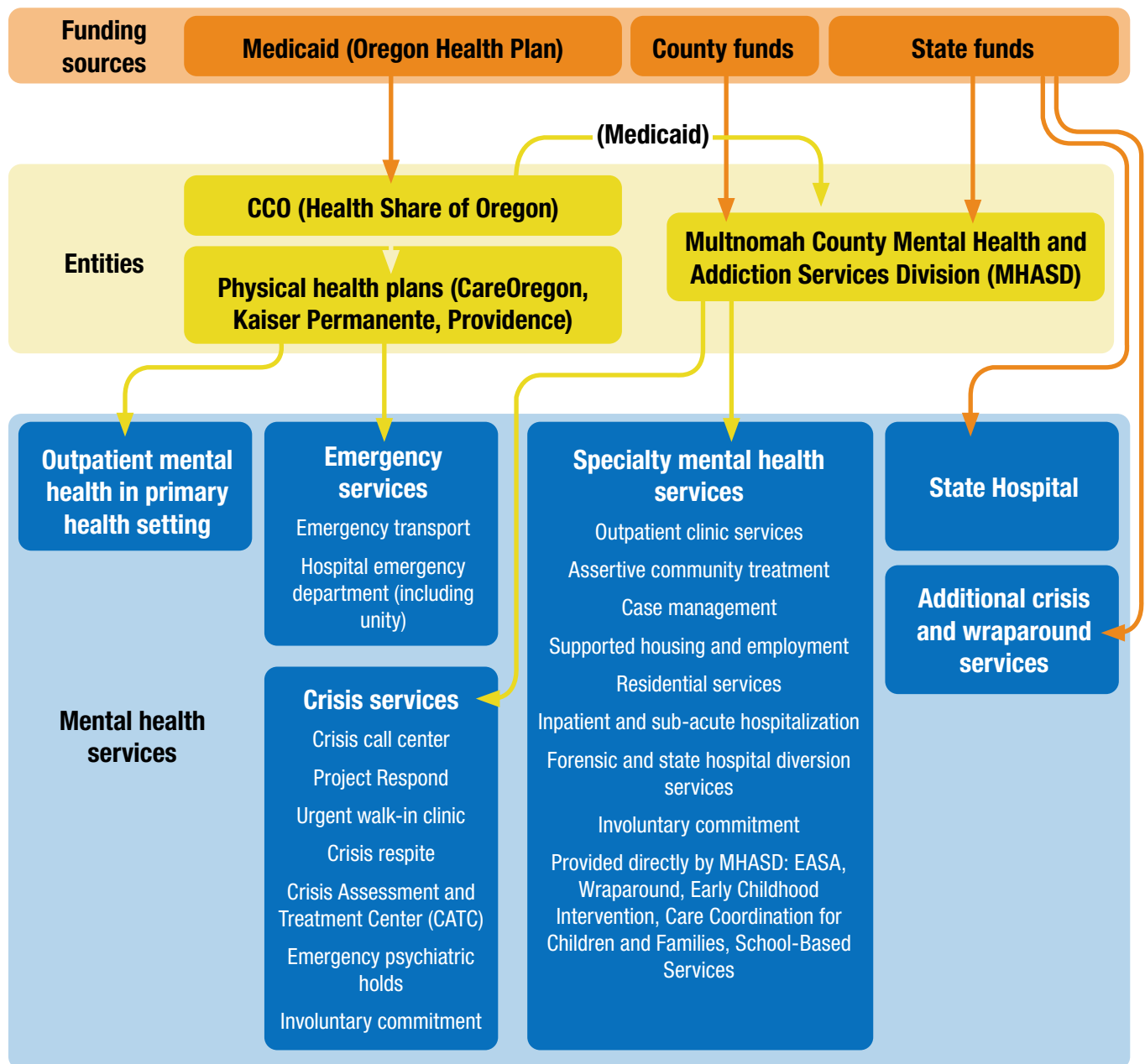
Notes: For simplicity, Figure 27 includes only publicly funded mental health services administered through Health Share or the Multnomah County Mental Health and Addiction Services Division (MHASD). It also does not include services that are funded through other payers such as Medicare and the Veterans Administration, which are administered at the federal level. This figure does not include services for individuals with mental health needs administered through other agencies, including Corrections Health, the Department of Community Justice, the Department of County Human Services, the Joint Office of Homeless Services, the Multnomah County Sheriff's Office, and local police departments in the county. The figure does not represent that the Oregon Health Plan directly funds services for a small number of Medicaid enrollees who are not assigned to a CCO. Figure 27 does not include substance use disorder treatment services, which are also primarily organized through MHASD.

* While this chart reflects funding for the behavioral health system from OHA, it does not represent additional funding for mental health that school districts or emerging school-based systems may provide. The school system recognizes the need for mental health resources and has been a regular resource for additional funding.

Figure 28: Mental health funding streams for Multnomah County

A combination of local, state and federal dollars funds Multnomah County's mental health system. These funds flow through Health Share to managing entities, physical health plans and Multnomah County's Mental Health and Addiction Services Division (MHASD), which administer a range of services.

The arrows represent how dollars from the three primary funding sources flow to mental health services via the two primary entities that have authority and responsibility for managing and overseeing those services.



Acronyms: CCO: coordinated care organization; EASA: Early Assessment and Support Alliance

(HSRI, 2018)



Hernandez, Hector. (2012). Revival of Hope and Wellness. [Porcelain tile and glass mosaic on wall]. Virginia Garcia Memorial Health Center, Cornelius Wellness Center. Cornelius, OR. Reprinted with permission.

Perceived disincentives to provide culturally specific services

Providers also perceived funding restrictions that acted as barriers to providing culturally specific mental health services and focusing on social determinants of health, such that state and local funding mechanisms and decision-making processes reward white-led and mainstream service organizations rather than culturally specific programs. Some interviewees suggested granting greater autonomy to schools, community-based legal services and churches to guide investments in mental health services for Latino/a/x communities (St. Amour, 2017). Interviews with community partners also revealed that program managers would like to better integrate traditional health workers, *curanderos* and traditional healers into mental health services for Latino/a/x clients; however, they were limited by the inability to bill for (or compensate others for) these services (St. Amour, 2017).



Mental health efforts in Oregon



Mental health efforts in Oregon



This section addresses recent legislation and other efforts to meet the mental health needs of Oregon's Latino/a/x communities.

Oregon has prioritized mental health policy

Coordinated care organizations are increasing their attention to mental and behavioral health

Oregon has increasingly pivoted toward a collective focus on improving and expanding behavioral and mental health services in recent years. Since the state's 2012 Medicaid waiver, Oregon's coordinated care organizations (CCOs) have had the explicit task of leveraging Medicaid dollars to motivate and accelerate the integration of physical, mental and behavioral health services.

As part of Oregon's continued efforts to transform the health care system, Governor Brown asked the Oregon Health Policy Board to focus on four key areas as they developed requirements for the next round of coordinated care organization contracting (Oregon Health Authority, CCO 2.0). One of these key areas was improving the behavioral health system; CCOs will be held more accountable for developing a person-centered behavioral health system and for removing barriers to accessing behavioral and mental health care. CCOs will be required to be fully accountable for the behavioral and mental health benefit, address billing barriers and improve health information technology for behavioral and mental health providers.

CCOs will also be asked to increase their investments and focus efforts to improve health outcomes and advance health equity, including building their own organizational capacity and infrastructure to address health equity and increasing the use of traditional health workers to support increased access to culturally and linguistically responsive health services.

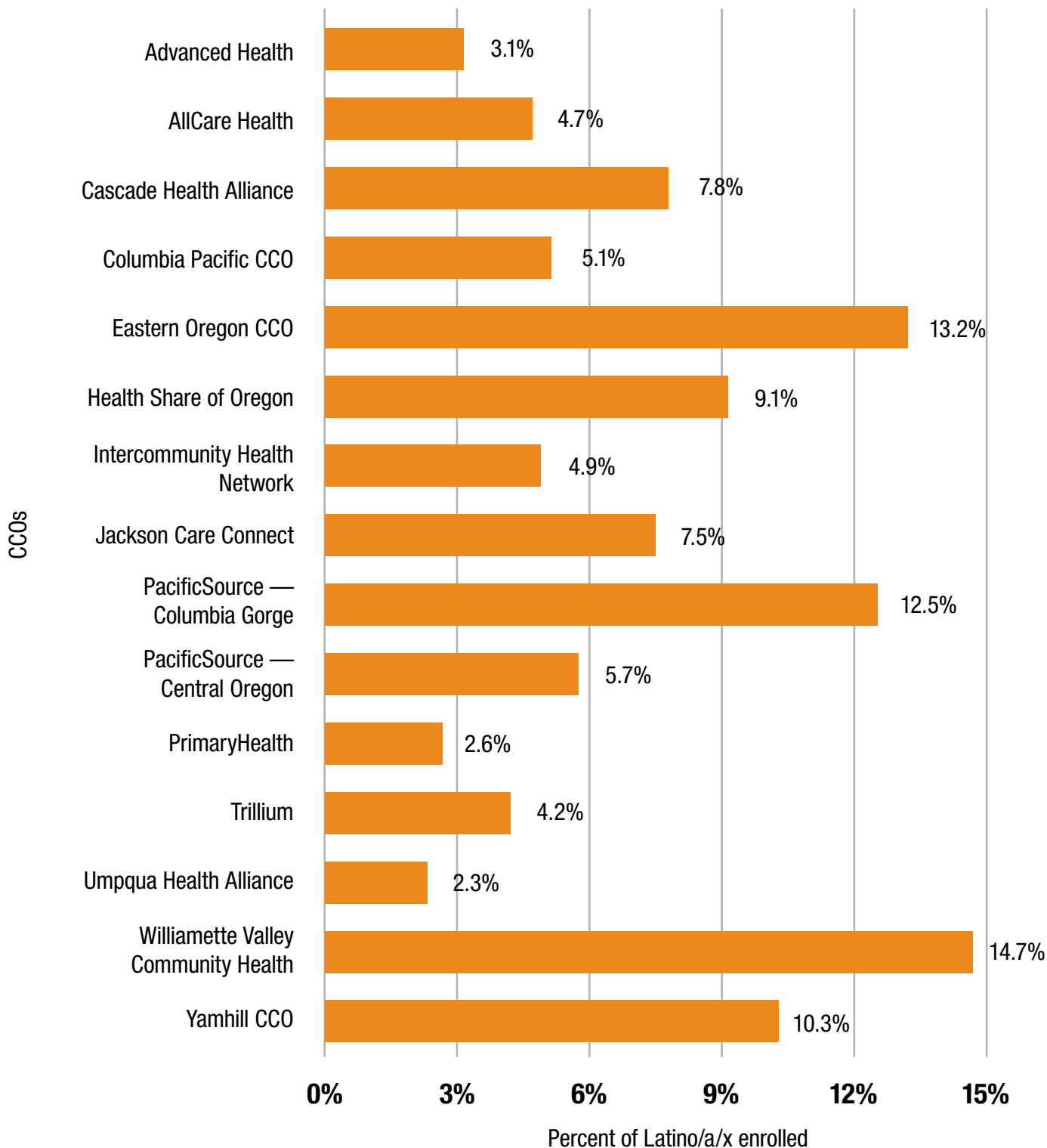
To help shape CCO 2.0 requirements, the Oregon Health Authority's Office of Equity and Inclusion (OEI) consulted with traditional health workers, peer support and wellness specialists, and an alliance of culturally specific health care providers to discuss how to identify and implement culturally and linguistically specific best practices to ensure access to and use of culturally and linguistically specific programs. Providers included Central City Concern's Puentes program, OHSU's Intercultural Psychiatric Program, OHSU's Avel Gordly Center for Healing, Lutheran Community Services Northwest, NAYA Family Center and other organizations.



OHA's Office of Equity and Inclusion drafted foundational questions to help CCOs develop their implementation plans, as well as improve their engagement and representation from specific communities.

Across Oregon's CCOs, Health Share (Portland Metro) and Willamette Valley Community Health currently serve the greatest numbers of Latino/a/x enrollees. While Yamhill CCO, Pacific Source—Columbia Gorge, and Eastern Oregon CCO serve smaller overall numbers of enrollees, more than one in 10 members are also Latino/a/x.

Figure 29: Percent Latino/a/x enrollment in Oregon's CCOs, May 2019

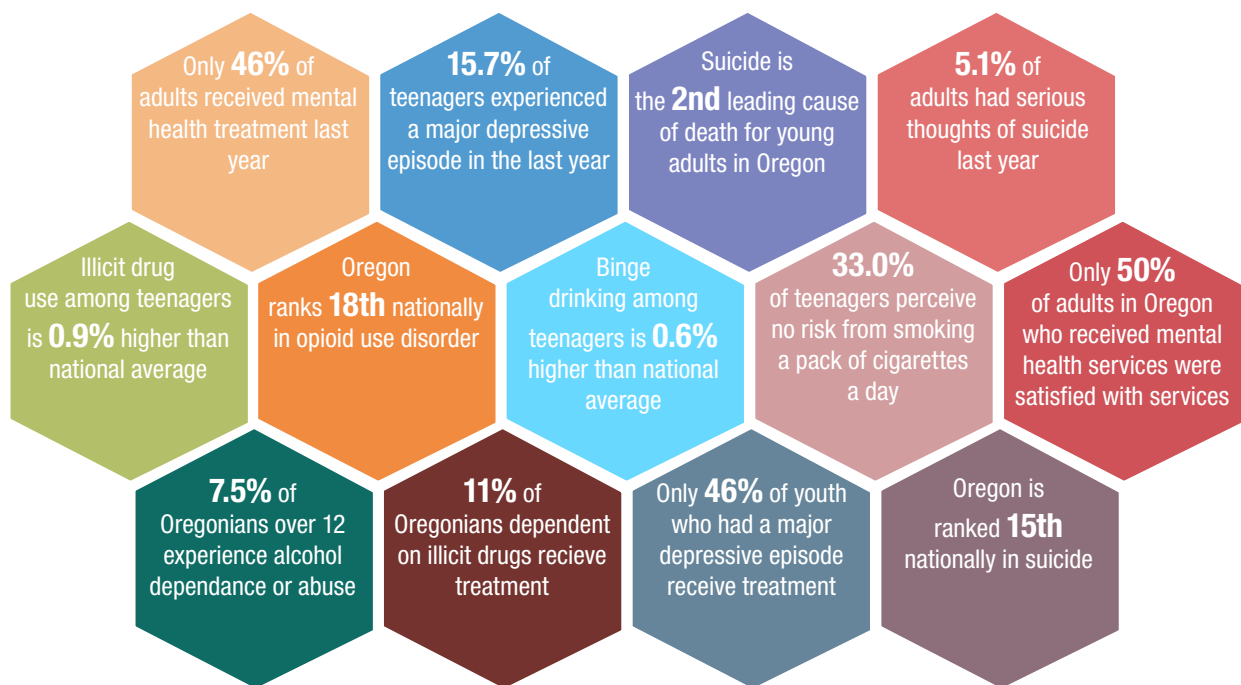


(Oregon Health Authority: Opportunities for Oregon's Coordinated Care Organizations to advance health equity, 2017.
<https://www.oregon.gov/oha/HPA/dsi-tc/Documents/CCO-Opportunities-to-Advance-Health-Equity.pdf>)

OHA's Behavioral Health Collaborative worked to transform the behavioral health system

In 2016, the Oregon Health Authority launched the Behavioral Health Collaborative to develop recommendations to build a 21st century behavioral health system. The goal was to ensure that behavioral and mental health are integrated with physical and oral health, and that every Oregonian has access to the services they need (Oregon Health Authority, Behavioral Health Collaborative). Data show that Oregonians are not currently receiving sufficient or consistent behavioral and mental health services and there are many ways to improve.

Figure 30: Behavioral and mental health in Oregon



(Oregon Health Authority, Behavioral Health Collaborative)

Oregon Behavioral Health Collaborative recommendations

1. Governance and finance — a single point of shared responsibility for local communities through a regional governance model. All organizations in a community that are responsible



for behavioral and mental health will be included in the governance structure to ensure care coordination and effective use of resources.

2. Standards of care and competencies — a minimum standard of care for all behavioral and mental health workers so Oregonians receiving behavioral and mental health services will have consistency.
3. Workforce — a needs assessment of the current behavioral and mental health workforce and a plan to build the workforce.
4. Information exchange and coordination of care — a call for data and measurement that is outcome-focused and patient-centered and the use of technology to integrate and help care across the behavioral health system.

The Behavioral Health Collaborative's recommendations resulted in an assessment of the behavioral and mental health workforce and [recommendations on recruitment and retention of the behavioral health workforce](#) (Oregon Health Authority, Healthcare Workforce Reporting). Specific recommendations included strategies for diversifying the behavioral and mental health workforce by focusing on expanding the pipeline for culturally and linguistically competent professionals entering the field. Expanding funding for scholarships, loan reimbursement programs and other financial incentives were some of the recommended strategies for doing so.

The Regional Behavioral Health Collaborative (RBHC) was a product of the Behavioral Health Collaborative recommendations. It was initiated in the tri-county area. The RBHC brought together multiple sectors to collectively address and prevent behavioral and mental health challenges with a focus on activities that can make an impact in 12 to 24 months. Activities include peer-delivered services and a focus on substance use disorder (SUD). The RBHC was divided into the following three work groups, each of which developed plans for addressing behavioral and mental health needs.

- The Communities of Color Work Group secured funding from Health Share of Oregon to develop three SUD recovery houses, one each for African Americans, Native Americans and Latino/a/x women with children. Each recovery house will include culturally specific peer services, outreach and community engagement. These services will also be available to non-recovery house residents. In addition, culturally specific peer services will be developed for immigrants and refugees and Latino youth. The funding also supports the MetroPlus Association of Addiction Peer Professions to produce an environmental scan of culturally specific SUD services and workforce in the region. Bridges for Change is the fiscal sponsor partnering with culturally specific organizations for implementation including Instituto Latino, NARA, Miracles Club, 4th Dimension, and Lutheran Community Services Northwest.

- The Medical Community Collaboration Work Group began development, supported by OHA, of a resource document to assist medical settings and recovery peer agencies that are, or are contemplating, adding recovery peers to enhance medical responses to individuals with SUDs. Due to COVID, this work has been put on hold.
- The Youth & Families Work Group proposed a project to implement peer delivered services to support youth in foster care. No resources have been identified at this time.
- As established at the inception of the RBHC, the purpose was to identify goals through each of the work groups. With that complete, the RBHC work will continue through the implementation of the work group identified projects.

County agencies stepping up

Other key partners in collectively improving and expanding mental health services include contracted local mental health authorities (public and private entities designated by the state to provide county mental health and crisis services), physical health plans that pay directly for outpatient mental health services, and emergency departments.

Between 2017 and 2019, Oregon was one of eight states to pilot a two-year Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration of certified community behavioral and mental health clinics (CCBHC). The CCBHCs were tasked with directly providing nine types of behavioral health services, with an emphasis on providing 24-hour crisis care, use of evidence-based practices, care coordination, and integration with physical health care for Medicaid members (Oregon Health Authority, Community Behavioral Health Clinics). CCBHCs are required to provide assistance in multiple languages. Their providers must be current on cultural competency trainings and monitor metrics related to youth and family cultural experience surveys. The CCBHCs have extended beyond the pilot through federal extensions; Oregon is examining longer-term sustainability. The Oregon Health Authority is also partnering with legislators, county courts and law enforcement to help keep people with mental illness out of jail and find treatment and housing in their own communities, in part to address capacity issues at the Oregon State Hospital (Oregon Health Authority, Addictions and Behavioral Health Services).

Multnomah County's Community Health Improvement Plan

Multnomah County's most recent Community Health Improvement Plan, developed in partnership with the Oregon Health Equity Alliance, established five priorities for improving health equity:

- 1. Access to culturally and linguistically responsive health care**
- 2. A neighborhood home for all**



3. Essential community services and resources
4. Supporting family and community ways
5. Transformative change for equity and empowerment

Within Priority #1, goals include diversifying the health care workforce to reflect the changing racial and ethnic demographics and need in Multnomah County; eliminating barriers facing communities ineligible for insurance or underused; and ensuring that all people are provided timely responsive health care inclusive of mental health, oral health and vision services. Specific attention is given to ensure this is true for people of color, LGBTQ2I, people with mental illness and people with disabilities (Change CP, 2020).

The Mental Health and Addiction Services Division (MHASD) at the Multnomah County Health Department has begun providing culturally specific mental health services for five groups, including Latinos/as/x, Pacific Islanders, African Americans, Eastern Europeans and Native Americans. In 2016, MHASD added five culturally specific mental health consultants to their staffing. In 2017, 934 individuals without insurance received culturally specific mental health services.

MHASD has also begun providing culturally specific treatment within Head Start programs, serving 3,600+ children through this program in 2017. 2018 marked the beginning of a pilot of school-based mental health services in grades K–3. The pilot involves complex case management and psychiatric consultation for students and families in all six school districts.

MHASD has also funded Speak Up and Empower, a partnership with the Latino Network that engages Latino/a/x youth ages 12–21 who have been affected by mental illness and who are enrolled in Multnomah County’s wraparound initiative. Youth meet once a month for nine months, participating in facilitated workshops and developing skills to advocate on behalf of mental health issues, including becoming elected members of Multnomah County’s Systems of Care Collaborative.

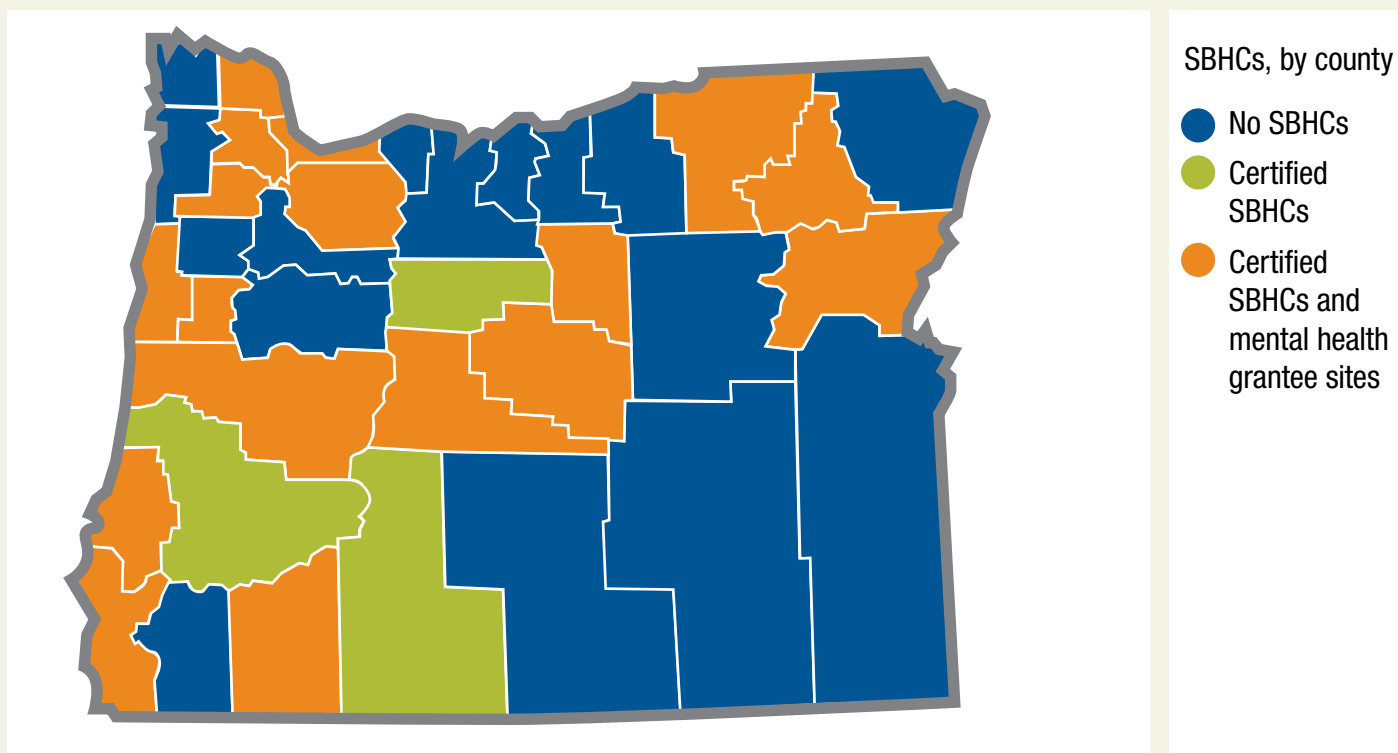
Community stakeholders have also recognized Multnomah County for prioritizing development of networks and alliances among bilingual and bicultural mental and behavioral health providers and culturally specific organizations, including the Alliance of Culturally Specific Behavioral Health Providers and Programs. The county has worked collaboratively with these partners to more effectively fund and expand the region’s culturally specific services.

Legislative attention for youth mental health needs: 2013–2015

Oregon's 2013–2015 legislative budget included \$21.8 million from the general fund for the expansion of children's and adolescents' mental health services. This funding created the Addictions and Mental Health (AMH) Investments Project. Thirty-nine school-based health centers across the state received more than \$4 million to add or expand mental health staffing capacity and support mental health projects (including mental health screening tools, tele-behavioral and -mental health, youth advisory committees, supporting culturally competent care and improving data collection).

House Bill 2445 (2013) also required the development of rules, procedures and criteria to certify school-based health centers (SBHCs) and created a work group to study best practices for SBHCs.

Figure 31: Oregon school-based health center mental health grantees, 2013–2015



(Oregon Health Authority. Health Policy and Analytics Division.

<https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Pages/funding.aspx>)

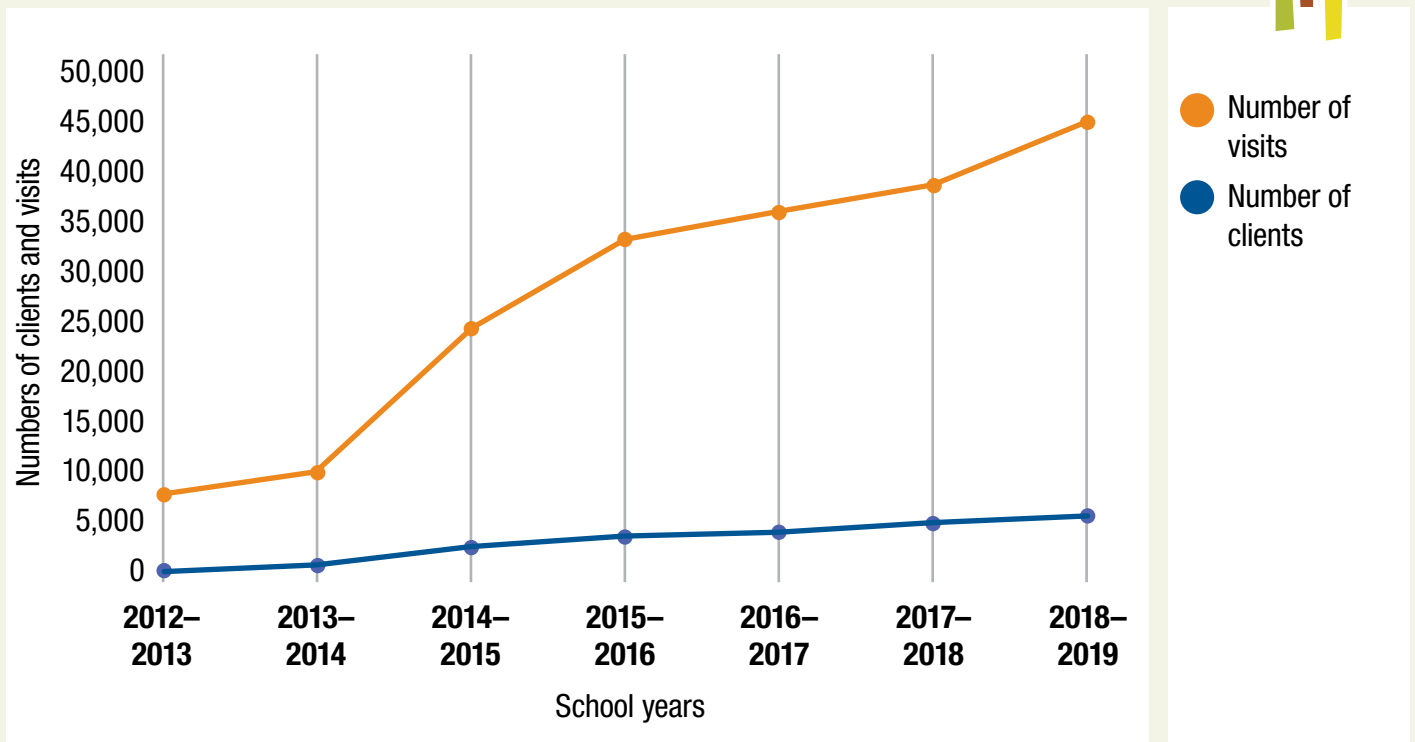
This 2013 AMH Investments Project also created health service advocate positions in Lincoln County and Youth-Participatory Action Research training projects in Deschutes, Jackson and Washington counties. Health service advocates were based at SBHCs to help students and families access physical and behavioral and mental health and social services.

Youth advisory councils and Youth Participatory Action Research projects focused on mental health stigma, teen substance use, suicide prevention, sleep, self-esteem, stress, and awareness of mental health issues and perceived barriers to accessing care (Oregon Public Health Division, 2016).

As a result of these investments, the number of clients served by and the number of visits to SBHCs from 2012–2019 increased by more than 400%, from 1,239 to 6,466 clients and from 8,532 to 43,982 visits (Oregon Public Health Division, n.d.), respectively (Figure 32).

Additional mental health staffing also resulted in a 91% increase in mental health visits in the 2014–2015 school year (compared to the prior year) (Oregon Public Health Division, 2016).

Figure 32: SBHC trends in behavioral health visits and clients



(Oregon Health Authority, 2012–2019 Oregon SBHC Encounter Data [J. Fabrick, personal communication, October 29, 2020])

What are school-based health centers?

School-based health centers (SBHCs) are a key model for integrating mental health services in K–12 settings to reach at-risk Latino/a/x youth. SBHCs are medical clinics that offer a full range of physical, mental and preventive health services to students on a school campus, regardless of a student's ability to pay. By providing easy access to health care, SBHCs reduce barriers such as cost, transportation and concerns about confidentiality that keep children and youth from seeking the services they need.

Research suggests SBHCs are effective in reducing barriers to care, such as access, transportation, stigma and ability to pay for services for families of low-socioeconomic status and are promising models for reduction of access disparities for minority populations (Guo et al., 2008; Guo et al., 2010).

Oregon's network of school-based health centers was established in 1986 and is supported by the Oregon Health Authority's Public Health Division. As of July 1, 2019, Oregon had 79 certified SBHCs in 26 counties. Seventy-four percent of the SBHCs are federally qualified health centers (FQHCs) and 48% are recognized by Oregon as patient-centered primary care homes (PCPCHs) (Oregon Public Health Division, n.d.).

How are school-based health centers funded?

The Oregon Health Authority provides general fund dollars to support on-site mental health providers at SBHCs. Currently, every SBHC has a mental health provider on-site. Mental health services are typically provided by the local mental health authority. However, state funding is not sufficient to fully operate an SBHC (Rahe, 2018). Local funding is sometimes used to supplement SBHC staffing. For example, in Multnomah County, funding supports SBHC staffing as well as additional mental health staff available outside of the SBHCs in 47 schools throughout the county (HSRI, 2018).



Hernandez, William. (2019). My Birthday Dream. [Acrylic on canvas]. Reprinted with permission.

Generally, SBHCs can be reimbursed for providing mental health services directly to individual patients; however, they are not reimbursed for some services such as group or classroom education. Some SBHCs pair behaviorists who work with primary care practitioners to offer brief, focused interventions, which has been identified as an effective mental health treatment strategy but is not currently fully reimbursable.

Licensed providers are not always available, so SBHCs sometimes cannot bill private insurance. SBHC certification standards require a qualified mental health professional (QMHP), but some SBHCs instead employ qualified mental health associates (QMHAs) because of lack of provider availability (Oregon Commission on Hispanic Affairs Policy Work Group, December 2018 Minutes). QMHAs are often not able to bill fully and are less likely to be reimbursed by private insurance, in general because of the challenging credentialing process.

Who uses Oregon's school-based health centers?

More than a third of all SBHC visits in 2018 were to see a mental health professional.

Figure 33: Number of Oregon SBHC visits, by provider type, 2018



SBHC mental health services include individual counseling, group counseling, family therapy, substance use disorder screening and assessment, depression and suicide screening, and classroom prevention education. More than half of all youth who used SBHCs reported their school clinic as their primary source of mental health care, and more than half (52%) are covered by Medicaid.

25% of all students seen at SBHCs by mental health staff were Latino/a/x.



21 SBHCs (28%) serve a student population that is majority students of color.



(Oregon Public Health Division, n.d.)



Trauma-Informed Schools Pilot Project: 2015–2017

In 2016, as part of a statewide chronic absenteeism plan (House Bill 4002), the Oregon Department of Education established a pilot program with two trauma-informed schools: Tigard High School and Central High School serving Independence and Monmouth. Both high schools had certified SBHCs that were active partners in the pilot program.

A “trauma-informed approach” was defined in House Bill 4002 as “an approach that recognizes the signs and symptoms of trauma in students, families and staff and responds by fully integrating knowledge about trauma into policies, procedures and practices for the purposes of resisting the recurrence of trauma and promoting resiliency.” In practice, a trauma-informed schools approach translates to creating a safe, predictable, compassionate and equitable environment.

Those involved in the pilot implementation worked to develop greater understanding and support for how to recognize trauma and stress, build relationships between adults and students, normalize mental health supports and resiliency skills, and increase student empowerment. Additionally, each school has measurably increased its focus on equity.

Although it was expected to take five years to observe changes, within two years the schools reported:

- A 7% increase in regular attendance at Central High School
- A 4% increase in graduation rate at Tigard High School, including a 16% increase in graduation for Latino/a/x students, and
- Disciplinary referrals reduced by half at Tigard High School.

Oregon mental health professionals serving Latinos/as/x note that schools are a good “platform” for conducting mental health screenings and connecting Latino/a/x families with needed resources in a less threatening, more community-oriented setting (St. Amour, 2017).

“We need platforms for integrated systems. Schools are a platform – they reflect where people are going and how we can support their needs. Instead of 10 different ways of funding needs, we focus on creating the platform [in schools] ... and address the needs there ...”

— Program Director,
Oregon (St. Amour, 2017)



Legislative attention for youth mental health needs: 2015–2019

SBHCs funding for mental health support increased by almost \$2 million during the 2015–17 biennium, expanding mental health services to a total of 52 SBHCs (Oregon Public Health Division, n.d.).

The 2017–2019 biennium saw additional investments in student mental health and SBHCs. The 2017 legislative session included Senate Bill 944, which created a centralized call center to serve as a “one-stop shop” for providers seeking residential treatment for children.

In 2018, House Bill 5201 provided almost \$5 million in additional funding for school-based mental health and trauma support services, residential treatment centers, and a psychiatric crisis line (Enrolled House Bill 5201). SBHCs awards were based on a funding formula that looked at number of students eligible for free and reduced-price school meals, and the county ratio of behavioral and mental health providers to the population. SBHCs were able to request additional funding if they could justify need; for review of these requests, Oregon prioritized underserved students. This additional funding for SBHCs brought the total to 55 SBHCs supported through the state mental health investment (Oregon Public Health Division, n.d.).

Based on SBHC requests for additional funding, the Oregon Health Authority determined there was a \$1.1 million gap for increased SBHC mental health support. Proposed changes for the next biennium included funding for additional SBHCs (Oregon Public Health Division, n.d.) and adding need criteria such as suicidality and depression rates, based on the Oregon Healthy Teens Survey (Oregon Commission on Hispanic Affairs Policy Work Group, December 2018 Minutes).

Spotlight: Oregon Healthy Teens Survey

Oregon’s Healthy Teens Survey is a key source of data on youth mental health. The Oregon Health Authority administers the Oregon Healthy Teens Survey and Student Wellness Survey to assess health need and behavior in eighth and 11th graders every other year. These surveys include questions related to depression, suicide contemplation, suicide attempts, school climate, substance use, resilience, and bullying and harassment.

OHA publishes statewide and county level reports and provides schools and school districts with local data. Program staff run individual analyses of the data by request from schools, health system partners and other community stakeholders (Oregon Health Authority, Oregon Healthy Teens Survey).

2019 Student Success Act

In 2019, Oregon passed the historic Student Success Act (House Bill 3427), creating a new



business tax with revenues dedicated to early learning and K–12 education. HB 3427 also introduced additional accountabilities into the education system intended to improve academic performance, high school graduation rates and more. Funds were specifically earmarked as grant dollars to meet students' mental or behavioral health needs.

The Student Success Act was based on recommendations made by the Joint Committee on Student Success, a bipartisan group of legislators created in 2018 to study Oregon's education system and recommend legislative action to improve the state's schools. Shortages of counselors and social workers in schools, as well as crisis support services, was a common theme in statewide listening sessions (Oregon Commission on Hispanic Affairs Policy Work Group, October 2018 Minutes). One committee recommended increasing the number of counselors and mental health professionals available to K–12 students and reducing reliance on teachers for mental health interventions. They proposed to do this through partnerships with CCOs, county mental health providers and public health agencies, in addition to expanding school-based health centers (Oregon State Legislature, 2015).


Spotlight: Oregon School-Based Health Alliance

The Oregon School-Based Health Alliance (OSBHA) is a statewide nonprofit organization incorporated in 2006. OSBHA strengthens school health services and systems that promote the health and academic success of young people using the following guiding principles:

- Sustaining, strengthening and expanding school-based health centers
- Promoting diversity and equity that engages community and youth voices
- Advocating for and facilitating the integration of health, wellness and education

OSBHA is committed to working with systems, organizations, groups and youth to create innovative solutions to the youth mental health challenge. OSBHA serves as a bridge across multiple systems to align resources and maximize efficiencies for youth health and mental health services. OSBHA is part of key conversations and planning efforts focused on the need for youth mental health services and on developing strategies to enhance access to these services. They have successfully advocated for increased school-based mental health funding.

In addition to supporting direct mental health services, OSBHA is also committed to creating systemic change that promotes and normalizes mental health as a critical component to wellness. OSBHA developed and successfully advocated for key legislation that established trauma-informed school pilot sites and provides technical assistance to those schools.



OSBHA's focus is to expand availability of mental health prevention and treatment services for youth in schools and equity of access to those services. They strive to engage in practices that redistribute, share and build power to change systems of inequity and support the overall well-being of youth (Oregon School-Based Health Alliance, n.d.).

Spotlight: SUN Schools Model

Oregon Commission on Hispanic Affairs stakeholders agreed that schools were a good platform for Latino/a/x students to access mental health. Several interviewees mentioned this platform was already present in parts of the Oregon school system through a program called SUN Schools (Schools Uniting Neighborhoods).

The SUN Community Schools in Multnomah County are full-service neighborhood hubs where the school and partners from across the community come together to make sure kids and families have what they need to be successful — in school and in life. The SUN Service System represents one strategy for improving educational and economic outcomes for people of color, immigrants and refugees, and those experiencing poverty. The program focuses on early learning supports, family stability supports such as food and energy assistance, and advocacy, including for LGBTQ youth (Oregon Commission on Hispanic Affairs Policy Work Group, January 2019 Minutes).

“*The SUN school is the blueprint for how I think about serving a community. SUN schools are a great model and use schools as community centers.*”

— School Counselor,
Portland (St. Amour, 2017)

The SUN Community Schools in Multnomah County spans 90 schools, six school districts and five regional service centers. It provides mental health services at 38 schools, including 10 schools that have student health clinics. SUN employed five bilingual and/or bicultural providers at school health centers and one early childhood provider specifically for the Latino/a/x communities with children ages 0–5.

SUN served 31,289 students in 2018, 74% of whom were students of color (Oregon Commission on Hispanic Affairs Policy Work Group, January 2019 Minutes).

The SUN program aligns with mental health and addiction services for both insured and uninsured youth. Services for Medicaid-insured youth are billed to the Oregon Health Plan or referred to Health Share of Oregon. Uninsured youth are not denied service based on inability to pay and may be

referred to Multnomah Treatment Fund for services via Trillium, Options, Morrison Child & Family Services, or Lifeworks; these organizations include some bicultural providers, though they do not have culturally specific Latino/a/x services.

SUN has formal partnerships with two culturally specific Latino/a/x partners, including El Programa Hispano and Latino Network, and further coordinates with additional Latino/a/x programs including Puentes, Community Healing Initiative, Colegio de Padres, Western Conexiones, and others.

Promising models of care

Oregon-based groups are leading the way in recruiting and training a more culturally responsive workforce that understands the unique mental health needs of Latinos/as/x in Oregon

Community-based groups are offering new options for cultural competence training and online and in-person continuing education trainings for health professionals, such as Familias en Acción's partnership with California State University's Institute for Palliative Care (Familias en Acción, n.d.) that addresses topics including:

- Knowledge of common Latino/a/x cultural values that may affect health
- Strategies for building patient engagement
- Understanding how social determinants can affect care
- Ways to integrate community health workers and patient navigators into care, and
- Cross-cultural communication tools for difficult discussions.



Hernandez, Hector. (2019). Unity and achievement. [Acrylic on Interface fabric on wall]. FHDC (Farmworker Housing Development Corporation) Colonia Unidad. Woodburn, OR. Reprinted with permission.

Lutheran Community Services Northwest (Lutheran Community Services Northwest, 2020) offers a 40- and 80-hour Peer Support/Peer Wellness Training adapted for immigrants and refugees and

based on the state's standard program. It focuses on reducing stigma around mental health and emphasizing peer-to-peer support.

The Immigrant and Refugee Community Organization (IRCO) also operates a number of programs designed to recruit lower-income immigrants and refugees into health care professions and re-credential those with nursing backgrounds. Additionally, IRCO operates a Health Care Interpreter Training Program that meets the requirements for individuals to become qualified or certified health care interpreters in Oregon.

Spotlight: Strengthening Latino/a/x Mental and Emotional Health, 2018 Conference


Familias en Acción has also begun convening Oregon health professionals through an annual Latino/a/x health equity conference focused on Oregon's Latino/a/x communities. Their 2018 conference, "Strengthening Latino Mental and Emotional Health," highlighted understanding and integrating Latino/a/x psychology within health, mental health and social service systems (Familias en Acción, n.d.).

Peer supports and traditional health workers are promising strategies for boosting the bilingual and bicultural workforce

Community and advisory groups are increasingly calling for expanded investment in traditional health workers to reach underserved Communities of Color, including the Latino/a/x community (Human Services Resource Institute, 2018). In 2018, the Oregon Consumer Advisory Council proposed creating a peer-delivered services coordinator position within each coordinated care organization and county, modeled on Clackamas County's peer leadership position (Wellness and Healing Practices Committee).



Baker, L. (2018). OCHA Chair Irma Linda Castillo presenting at Familias en Accion Conference. OACO, Portland, OR. Printed with permission.



Community-based nonprofit organizations are developing programs and partnering with health systems to make bilingual and bicultural services available in their communities to help Latino/a/x clients navigate the health system and access health services. Some examples include:

- **The Next Door, Inc.** (The Next Door, 2019) operates a 90-hour Community Health Worker Training Program in The Dalles and Hood River areas.
- **Bienestar** (Bienestar, 2019) *promotores* are residents of affordable housing sites in Washington County. Through *pláticas* (home visits) to their neighbors, *promotores* provide information and make referrals to resources such as food assistance and English (ESL) classes.
- **Providence Health & Services** and **Pacific University** (Mosaic Medical, 2019) partner to train and embed volunteer *promotores* in Spanish-speaking parishes across the Portland Metro area who lead *charlas*, or community conversations about behavioral and mental health.
- **Adelante Mujeres** (Adelante Mujeres, 2019) leads a program that employs popular education to help participants heal from past trauma and strengthen emotional well-being and relationships.
- **Mosaic Medical Group** (Mosaic Medical, 2019) embeds community health workers within their Central Oregon primary care clinics to connect patients with community resources and health care interpreters trained in Spanish.

Promotores de Salud

Community health workers are members of a particular community who provide flexible, non-clinical supports to other community members; they are also referred to as *promotores*, indigenous paraprofessionals, natural helpers and community health representatives.

Promotores will assist clients in navigating the health care system, improving their health knowledge and self-sufficiency by helping them understand their health condition(s) and developing strategies to improve their health and well-being.

A recent review of the research on CHW- delivered interventions found these services are effective in improving mental health outcomes and in addressing disparities for underserved populations (Landers & Levinson, 2016).



Community and faith-based approaches

Through testimony to the Oregon Commission on Hispanic Affairs and in interviews, stakeholders have advocated for community-driven solutions to mental health and expressed a need for greater collaboration among providers and community members.

The Portland Metro area is making progress in this area. With support from Meyer Memorial Trust, the Latino Emotional Health Collaborative convened Latino/a/x-specific service organizations in Multnomah County in 2016 to address the numerous systemic and institutional barriers to mental, behavioral and emotional wellness for Latino/a/x communities in Oregon. To date, the Latino Emotional Health Collaborative consists of 10 partners with the Oregon Latino Health Coalition serving as the backbone agency.


Partners in the Latino Emotional Health Collaborative include:

Catholic Charities	Puentes Program
El Programa Hispano	Oregon Community Health Workers Association
Familias en Acción	Portland State University
Latino Network	Oregon Commission on Hispanic Affairs
Central City Concern	Providence Health & Services
Pacific University PsyD and MSW programs	

Interviews with community mental health providers also reveal a consensus that connecting with Latino/a/x communities in Oregon and providing mental health information via trusted community settings would increase awareness and reduce barriers (St. Amour, 2017). Holding culturally specific community events was suggested as one strategy to raise awareness of mental health issues and services. Providers across multiple regions have expressed interest in dedicated, culturally specific community centers for Latinos/as/x that integrate mental health services with other community events and resources such as childcare, meeting and recreational space (St. Amour, 2017).

Some community organizations already provide culturally specific health education classes, support groups and trainings on physical health conditions in schools and recreation centers. Some stakeholders identified these as opportunities to reduce stigma by integrating similar programs focused on mental and emotional well-being where Latinos/as/x are already connecting with these services.

For example, Familias en Acción in Portland and The Next Door in Hood River and The Dalles offer community health education workshops based on popular education for Latino/a/x families,



including chronic disease prevention and self-management programs, nutrition courses, and Spanish-language cancer and chronic disease support groups. The National Alliance for Mental Illness (NAMI) in Oregon offers a free, evidence-based, 12-week training program, De Familia a Familia, for families and friends of individuals with mental illness to become advocates.

Churches and clergy were also frequently identified by OCHA stakeholders and community partners as a trusted gathering place and source of information in the Latino/a/x communities, with potential to promote mental and emotional well-being. Models such as Providence Health & Services' Promotores de Salud de la Iglesia, launched in 2002, trains parish-based community health workers across Washington and Multnomah County to connect Latino/a/x families with health promotion resources and information.

Integrating mental health and primary care

Integrating mental health care into physical health care settings is an increasingly recognized best practice for improving mental health outcomes, particularly for racial and ethnic minorities. Since 2011, the Oregon Health Authority has promoted a road map for the integration of mental and physical care through its Patient-Centered Primary Care Home (PCPCH) Program, which now recognizes 600+ PCPCHs across the state (Smith & Merrithew, 2017). Mental health professionals serving Latino/a/x communities in Oregon described the PCPCH


“ *In my previous job, we had wraparound teams – family members, parish priests, curanderos, and we all aligned with how we were trying to help the family ... we did not shy away from embracing issues and did not label our services as mental health.*

We found what worked ... whether it was prayer groups or spiritual practitioners and we were a team. We were also a community event center. It wasn't a place to go if you have a problem. We were trusted and known.”

– Mental Health Provider,
Central Oregon (St. Amour, 2017)

“ *The church is a good place for Latinos/as/x to come. People have trust and it is a source of community and probably a good place to access mental health care. We somehow need to bridge the gap between the church and mental health providers.”*

– Church Administrator,
Portland (St. Amour, 2017)



model as a best-practice approach for improving access and services for Latino/a/x individuals.

Research supports these positive perceptions. Co-located physical and mental health services have been shown to be more effective at improving racial and ethnic minorities' mental health outcomes and reducing disparities (Lee-Tauler et al., 2018).

There is growing evidence that this model improves quality and access to care, and reduces costs (Cohen et al., 2017; Pomerantz et al., 2008). The model proactively engages patients in decision making, which improves adherence to treatment plans (Lindhiem et al., 2014).

Integrated care may be particularly promising for supporting Latino/a/x patients who are prescribed medication for depression. Latino/a/x are known to discontinue anti-depressant medication at a higher rate than non-Latino/a/x whites (Sanchez et al., 2015; Interian et al., 2011).

One promising model treated Latino/a/x patients concurrently for diabetes and depression through an integrated care model that combined medication, cognitive therapy, and support from bilingual social workers and patient navigators (Ell et al., 2010). The randomized trial revealed significantly improved mental health outcomes, medication compliance and patient satisfaction compared with traditional (non-integrated) care.

Provider interviews reveal that integrating mental health care in physical health care settings may be particularly effective because it eliminates the possible stigma associated

Oregon's Patient-Centered Primary Care Home Program


The Patient-Centered Primary Care Home (PCPCH) Program is the Oregon Health Authority's version of a patient-centered medical home designation.

The PCPCH program emphasizes six attributes:

1. Access to care
2. Accountability
3. Comprehensive, whole-person care
4. Continuity
5. Coordination and integration
6. Person- and family-centered care

To be considered a PCPCH, clinics are required to have a strategy for screening for mental and behavioral health, substance use and developmental issues, and a process to refer to services. There are five different tiers of recognition depending on various criteria; 5 STAR is the highest rating a clinic can achieve.

Beginning in 2017, the program was further refined to enhance mental and behavioral health integration into primary care (Oregon Health Authority, Patient-Centered Primary Care Home Program.).



with seeking care at a facility that exclusively provides mental health services.

Other providers noted that primary care providers are typically physicians, and some patients may perceive less stigma in accessing services via a medical doctor than through a mental health professional.

There are models of culturally inclusive, integrated physical, mental, vision and dental care in Oregon, including Virginia Garcia's Wellness Centers (Virginia Garcia, 2019) in Beaverton and Cornelius. In addition, Yakima Valley Farm Workers Clinic (YVFWC, 2019) in Portland, Salem, Hermiston and Woodburn are recognized patient-centered primary care homes in Oregon. In this model, health services are co-located in a single facility offering nutrition education in Spanish and English, wellness programs and connections to community resources such as food assistance.



“Integrated care works because when folks check in, no one knows why you are there. There is no stigma about mental health. The access is also there since if they go to their primary care doctor they can be referred. It is familiar and they feel welcome.”

— Mental Health Provider,
Oregon (St. Amour, 2017)



“Stigma plays into whether we are quacks. That is what is great about being in a primary care clinic because a doctor has status and respect and [patients] will listen if the doctor advises them to see a behaviorist. If the mental health services are co-located in the same building, then this increases access and reduces stigma.”

— Mental Health Provider
Oregon (St. Amour, 2017)

Tele-health can expand access in rural communities

Tele-health services have been proposed as a strategy to address Oregon's rural mental health workforce shortage. Community organizations, schools, rural hospitals and clinics can host equipment that connects patients with psychiatrists, psychologists and clinical social workers in other communities in order to receive counseling, cognitive behavior therapy, psychotherapy and other mental health services that are unavailable locally (University of Wisconsin Population Health Institute, 2019).



DeSiga, Daniel. (n.d.) Farmworkers working in a field on an open book. Reprinted with permission.

Since 2015, health service providers licensed in Oregon can provide Tele-health services (Oregon Health & Sciences University, 2020c). Both Medicare and Medicaid reimburse for telemedicine services provided via two-way videoconferencing but, prior to the COVID-19 pandemic, certain restrictions limited the use of Tele-health. During the pandemic, the Centers for Medicare and Medicaid Services (CMS) and states have relaxed Tele-health restrictions considerably, allowing new services and provider types, in addition to non-HIPAA compliant platforms, telephone visits and care across state lines (Manatt Health, 2020). In Oregon, reimbursements for Tele-health in both the Oregon Health Plan and among private payers were increased to be at parity with in-person services (State of Oregon Newsroom, 2020; Telemedicine, 2020). The federal government and states are considering which of these changes, if any, will become permanent.

Notably, these policy changes have made it significantly easier for people to access Tele-health appointments from their homes, but equity is an important consideration given barriers such as the digital divide and privacy and safety concerns.

These policy changes have made it possible for more people to access Tele-health appointments, and to do so from home rather than a doctor's office. However, significant barriers remain for many, such as lack of access to technology, lack of access to private and safe spaces for a Tele-health appointment, and cultural and language barriers to participating in virtual care (Oregon Health Authority, 2020).



Private payers in Oregon are also generally required to cover services provided via Tele-health if those services would be covered when provided via a face-to-face encounter (Oregon Revised Statute 743A.058). Tele-health may be a particularly promising strategy given the rural shortage of bilingual and bicultural behavioral and mental health professionals with training at the masters and doctoral level, and the lack of culturally specific acute care services in rural areas.

Tele-health is also an opportunity for health systems to partner with community-based organizations; for example, Providence Health & Services in Oregon is partnering with Familias en Acción to connect Latino/a/x families with nurse practitioners for health screenings (Familias en Acción, 2020). Currently, with the event of COVID 19, Tele-health has become the norm for many service providers.

Spotlight: Tele-mental health case studies

In a report prepared for the Oregon Commission on Hispanic Affairs, Hernandez (2018) documented several promising models for tele-mental health services, including:

- **University of Virginia Health System's** partnership with community mental health and primary care clinics to provide services to more than 13,000 rural adults via Tele-health consultations with psychiatric residents and fellows at UVA's School of Medicine.
- **University of Texas Medical Branch's** partnership with the Galveston school district's network of school-based health centers. They employ UT psychologists, psychiatrists and social workers to provide a wide range of mental and academic counseling services and case management, along with an online portal of resources, to reduce disparities in racial and ethnic minority students' access to counseling.
- **University of South Carolina School of Medicine's** partnership with the South Carolina Department of Mental Health to offer psychiatric services via Tele-health in 18 rural hospitals in order to reduce emergency department wait times and frequency and length of hospitalizations related to psychoses, drug-related mental health problems, and mood disorders.

Estoy hecha de retazos

Pedacitos coloridos de cada vida que pasa por la mía y que voy cosiendo en el alma.

No siempre son bonitos, ni siempre felices, pero me agregan y me hacen ser quien soy.

En cada encuentro, en cada contacto, voy quedando mayor..

En cada retazo una vida, una lección, un cariño, una nostalgia ...

Que me hacen más persona, más humana, más completa.

Y pienso que es así como la vida se hace: de pedazos de otras gentes que se van convirtiendo en parte de la gente también.

Y la mejor parte es que nunca estaremos listos, finalizados ...

Siempre habrá un retazo para añadir al alma.

Por lo tanto, gracias a cada uno de ustedes, que forman parte de mi vida y que me permiten engrandecer mi historia con los retazos dejados en mí. Que yo también pueda dejar pedacitos de mí por los caminos y que puedan ser parte de sus historias.

Y que así, de retazo en retazo podamos convertimos, un día, en un inmenso bordado de "nosotros".

Estoy hecha de retazos. Gracias por cada retazo.

(Translation on page 147)

Cora Coralina



Crisis de Nuestro Bienestar: Conclusions

Crisis de Nuestro Bienestar: Conclusions



We hope that this report has helped the reader better understand the importance of Latino/a/x mental health for all Oregonians. The data gathered in this report tell us not only that this population is the largest minority group, it is also the fastest growing one in the state. Among all the socioeconomic indicators and social predictors of health and wellness, perhaps none is more striking in terms of significance for the welfare of all Oregonians than the finding that 53% of Latino/a/x youth accessed mental health from K-12 referrals between 1983 and 2013 (significantly more than 30% of the general population) (Voelker, 2017). This finding is a clear direction for how the state can foster and support the crucial success of this population to thrive and meet its full potential. If the state is to reach the aspirational educational goal of 40/40/20 (40% four-year higher education, 40% two-year community college and 20% trade certification) for the 2025 state workforce, it must provide the wraparound health and mental health services needed for this 25% (and growing) Latino K–12 population. It behooves all Oregonians to ensure this growing group of young people achieve their fullest potential, earn their highest salaries and pay a substantial share of taxes that, in turn, will pay for services of benefit to all Oregonians.

To achieve economic, health and well-being success for this population, several recommendations are offered.

1. Build on Oregon's work toward health equity and increasing diversity in and providing training for the workforce. To do so, focus on the development of a training pipeline, and on the recredentialing of culturally and linguistically specific, trauma-informed mental health providers who earned their credentials in other countries. Such an effort would require an increase in systemic resources and implementation of policy and support of organizational structures to address the scarcity of mental health providers and support for those providers.
2. A concomitant increase in access to behavioral and mental health services by building systemic supports for comprehensive care in school districts and schools is also needed.
3. Establish as standard practice the appointment of practitioners of color, Communities of Color and other historically underserved groups on all licensing boards and public bodies.
4. Community integration is key: Integrating culturally and linguistically specific mental health care with community services that Latinos/as/x in Oregon regularly use will address three prominent barriers for Latinos/as/x in Oregon: access, retention and stigma. To address these barriers, create dedicated spaces and places for Latino clients by increasing systemic resources and implementing financial incentives to increase culturally specific mental health programming that combats stigma.



5. As suggested by the policy research model used in this report, provide resources and support data collection and analyses that center Latinos and other Oregon Communities of Color as an ongoing activity.
6. The Higher Education Coordinating Commission should work with the Oregon Department of Education to address provider behavioral and mental health training and workforce needs.
7. To assess such needs, establish a Latino/a/x mental health task force and a culturally specific mental health task force that address equity for Latinos and other Communities of Color in Oregon using *Crisis de Nuestro Bienestar* to develop an action agenda for the Oregon Legislature.

The time has come for a response to this call to action, to meet the mental and behavioral health needs of Latino/a/x communities and provide care that is Latino/a/x-centered.

Translation of “Quilt of Life” by Cora Coralina:

For questions or interest, please contact:

Nancy Kramer, Oregon
Advocacy Commissions
Office
503-302-9725

Quilt of Life

I'm made of scraps.

Colorful bits of every life that goes through mine and that I'm sewing into my soul.

They're not always pretty or always happy, but they add me and make me who I am.

In each meeting, in each contact, I get older ...

In each challenge a life, a lesson, an affection, a nostalgia.

That make me more person, more human, more complete. And I think that's how life is made: from pieces of other people who become part of people too.

And the best part is that we will never be ready or finished ...

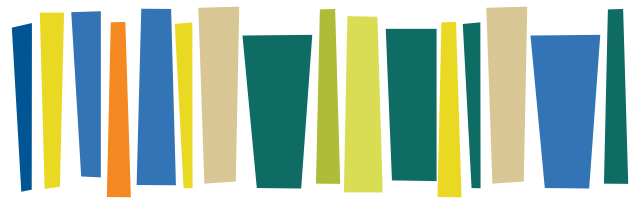
He always has a scrap to add to the soul.

Therefore, thank you to each of you who are part of my life and who allow me to magnify my story with the scraps left in me. That and I can also leave bits of me on the roads and that they can be part of their stories.

And so, from patch to patch we can convert, one day, into an immense embroidery of “us”.

Cora Coralina. Poetisa carioca

Glossary of terms



Behavioral health: the spectrum of behaviors and conditions comprising mental health, substance use disorders and problem gambling. The term “behavioral health” is used throughout this report only in instances that refer to the overall behavioral health system, or to specify that both behavioral and mental health care are relevant.

Behavioral health providers: practitioners who serve people seeking help for a variety of mental health and substance use needs, in settings from prevention programs to community-based and inpatient treatment programs (Scope of Practice Policy, n.d.)

Community-based participatory research (CBPR): a partnership approach to research that equitably involves community members, organizational representatives, researchers and others in all aspects of the research process. All partners in the process contribute expertise and share in the decision-making and ownership. CBPR aims to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions for policy or social change benefiting community members. (Bartuch, 2017; Israel, et al., 1998; Meenahan, et al., 2004; Soriano, 2012)

Coordinated care organizations (CCOs): a network of all types of health care providers (physical health care, addictions and mental health care, and dental care providers) working together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and helping people manage chronic conditions, such as diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy. (Oregon Health Authority, n.d., Coordinated Care Organizations)

Community advisory council: a type of [advisory board](#) consisting of representatives of the public, community leaders, stakeholders and others who meet with representatives of an institution to relay information between the two groups. CACs, within the research structure of the Oregon Advocacy Commissions, are especially associated with applied policy research and [community-based participatory research](#) about complex, equity-focused issues and policy remedies affecting Communities of Color and women throughout Oregon.

Cultural complexity: describes the effect of accounting for clients’ deeply held cultural values, viewpoints, experiences and beliefs in mental and behavioral health care. It includes a variety of factors relevant to clients from historically underserved groups that require a mental or behavioral health provider to learn about and attend to a client’s unique history (e.g., trauma response within refugee or immigrant groups, racial trauma, systemic discrimination, among many) in order to attune to a client and provide quality mental health care. Since more cultural complexity typically requires



more time building trust, learning, and developing relationship, accounting for cultural complexity is particularly important when considering mental or behavioral health providers' caseload capacity (Tummala-Narra, 2016). The concept "cultural complexity" is layered and rich; the OACs hope to do more work to fully articulate this concept. (For further discussion on this topic, please see pages 115–117.)

Culturally specific modalities: in this study, refers to culturally sensitive therapeutic practices and integrative frameworks. These include acculturation, language, cultural norms, and values and beliefs used to assess psychological and physical health, including interventions strategies appropriate for the context, culturally. Culturally specific modalities are a growing area of mental health and behavioral practice and provide a method of developing effective treatment programs for clients with wide ranging cultural backgrounds. (Alvarez-Hernandez & Choi, 2017; Sevilla, et al., 2018; Valentine, et al., 2016) For further discussion on this topic, please see Appendix 1.

Local mental health authority (LMHA): one of the following entities:

- The board of county commissioners of one or more counties that establishes or operates a community mental health program
- The tribal council in the case of a federally recognized Tribe of Native Americans that elects to enter into an agreement to provide mental health services, or
- A regional local mental health authority composed of two or more boards of county commissioners.

Mental health care: care to help people with or at risk of mental illnesses— to suffer less emotional pain and disability and live healthier, longer, more productive lives. A variety of caregivers provide this care in diverse public and private settings such as specialty mental health, general medical, human service and voluntary support networks. (adapted from SAMHSA) (Peek & the National Integration Academy Council, 2013)

Mental health provider: professionals who diagnose mental health conditions and provide treatment. Most have at least a master's degree or more advanced education, training and credentials. (Mayo Clinic, n.d.)

NAMI: The National Alliance on Mental Illness: the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. (National Alliance for Mental Illness, 2020)



NIMH: National Institute of Mental Health: the lead agency for all federally funded mental health research. (National Institute of Mental Health, n.d.)

Oregon Advocacy Commissions Office (OACO): The [Oregon Advocacy Commissions Office \(OACO\)](#) was established to support the statutory work of the [Oregon Commission on Asian and Pacific Islander Affairs](#) (OCAPIA), [Oregon Commission on Black Affairs](#) (OCBA), [Oregon Commission on Hispanic Affairs](#) (OCHA), and the [Oregon Commission for Women](#) (OCFW). The Oregon Advocacy Commissions Office supports the Oregon Advocacy Commissions' policy advising and policy research across seven strategic priority areas by identifying intersectional issues, best practice, rural and urban analysis, and by researching policy remedies, growing partnerships within and between state government and community stakeholders, and supporting data and equity informed decision-making. (Oregon Advocacy Commissions Office, n.d.)

OACs: Oregon Advocacy Commissions: The [Oregon Commission on Asian and Pacific Islander Affairs](#) (OCAPIA), [Oregon Commission on Black Affairs](#) (OCBA), [Oregon Commission on Hispanic Affairs](#) (OCHA), and the [Oregon Commission for Women](#) (OCFW) are collectively known as the Oregon Advocacy Commissions. Each of the OACs has nine Governor-appointed commissioners and two legislators appointed by the Senate president and speaker of the House and confirmed by the Senate. The OACs bring the voice and equity lens of underrepresented communities statewide to the policy table. They research issues, inform and advise state policymakers and decision makers — including the Governor, legislators and departmental leadership — on increasing all Oregonians' success and growing diverse leadership into state government. (Oregon Advocacy Commissions Office, n.d.)

Oregon Commission on Asian and Pacific Islander Affairs (OCAPIA): OCAPIA empowers and supports Asian and Pacific Islanders in Oregon through commissioners' special role as policy advisors to Oregon state policymakers and leaders. The OCAPIA promotes partnerships between state government and community members in rural and urban areas to ensure success for all Asian and Pacific Islander Oregonians by addressing longstanding and emerging issues at the policy level. (Oregon Advocacy Commissions Office, n.d.)

Oregon Commission on Black Affairs (OCBA): OCBA empowers and supports the African American and Black community through commissioners' special role as policy advisors to Oregon state policymakers and leaders. The OCBA promotes partnerships between state government and community members in rural and urban areas to ensure success for all African American and Black Oregonians by addressing longstanding and emerging issues at the policy level. (Oregon Advocacy Commissions Office, n.d.)



Oregon Commission for Women (OCFW): OCFW empowers and supports women through commissioners' special role as policy advisors to Oregon state policymakers and leaders. The OCFW promotes partnerships between state government and women in rural and urban areas to ensure success for all women by addressing longstanding and emerging issues at the policy level. (Oregon Advocacy Commissions Office, n.d.)

Oregon Commission on Hispanic Affairs (OCHA): OCHA empowers and supports Latinos/as/x through commissioners' special role as policy advisors to Oregon state policymakers and leaders. The OCHA promotes partnerships between state government and community members in rural and urban areas to ensure success for all Latinos/as/x by addressing longstanding and emerging issues at the policy level. (Oregon Advocacy Commissions Office, n.d.)

Oregon School-Based Health Alliance (OSBHA): strengthens school-based health services and systems that promote the health and academic success of young people by:

- Convening and connecting stakeholders in education and health care
- Acting as a statewide voice to protect and increase funding for Oregon school-based health centers
- Aligning efficiencies and resources so SBHCs can provide more direct service, leverage existing funding and achieve sustainable growth. (Oregon School-Based Health Alliance, n.d.)

Participatory action research (PAR): an approach to research that emphasizes participation, power-sharing and action in communities. It seeks to understand the world by trying to change it, collaboratively and following reflection. PAR emphasizes collective inquiry and experimentation grounded in experience and social history. Within a PAR process, "communities of inquiry and action evolve and address questions and issues that are significant for those who participate as co-researchers." (Bartuch, 2017; 1998; Meenahan, et al., 2004; Reason & Bradbury, 2008)

Qualified mental health associate (QMHA): an individual delivering services under the direct supervision of a qualified mental health professional (QMHP) who meets the minimum qualifications as authorized by the local mental health authority (LMHA) or designee and specified in Oregon Administrative Rule 309-019-0125 (Outpatient Behavioral Health Services Specific Staff Qualifications and Competencies, n.d.)

Qualified mental health professional (QMHP): a licensed medical practitioner or any other individual meeting the minimum qualifications as authorized by the local mental health authority (LMHA) or designee and specified in Oregon Administrative Rule 309-019-0125 (Outpatient Behavioral Health Services Specific Staff Qualifications and Competencies, n.d.)



Substance Abuse and Mental Health Services Administration (SAMHSA): The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral and mental health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. (Substance Abuse and Mental Health Services Administration, n.d.)

Social action research (SAR): a philosophy and methodology of research generally applied in the social sciences. It seeks transformative change through the simultaneous process of acting and doing research, linked together by critical reflection. Kurt Lewin, then a professor at Massachusetts Institute of Technology (MIT), first coined the term "action research" in 1944. In his 1946 paper, "Action Research and Minority Problems," he described action research as "a comparative research on the conditions and effects of various forms of social action and research leading to social action" that uses "a spiral of steps, each of which is composed of a circle of planning, action and fact-finding about the result of the action." (Bartuch, 2017; 1998; Lewin, 1958; Meenahan, et al., 2004; Reason & Bradbury, 2008)

School-based health centers (SBHCs): a unique health care model for comprehensive physical, mental and preventive health services provided to youth and adolescents either within a school or on school property. With easy access to health care in a school setting, SBHCs reduce barriers such as cost, transportation and concerns surrounding confidentiality that often keep children and youth from seeking the health services they need. SBHCs provide a full range of physical, mental and preventative health services to all students, regardless of their ability to pay. (Oregon Health Authority, Behavioral Health Collaborative)

Specialty mental health services: special health care services for people who have a mental illness or emotional problems that a regular doctor cannot treat. These services include crisis counseling, individual/group/family therapy, medication management and recovery services. (San Bernardino Behavioral Health, n.d.)

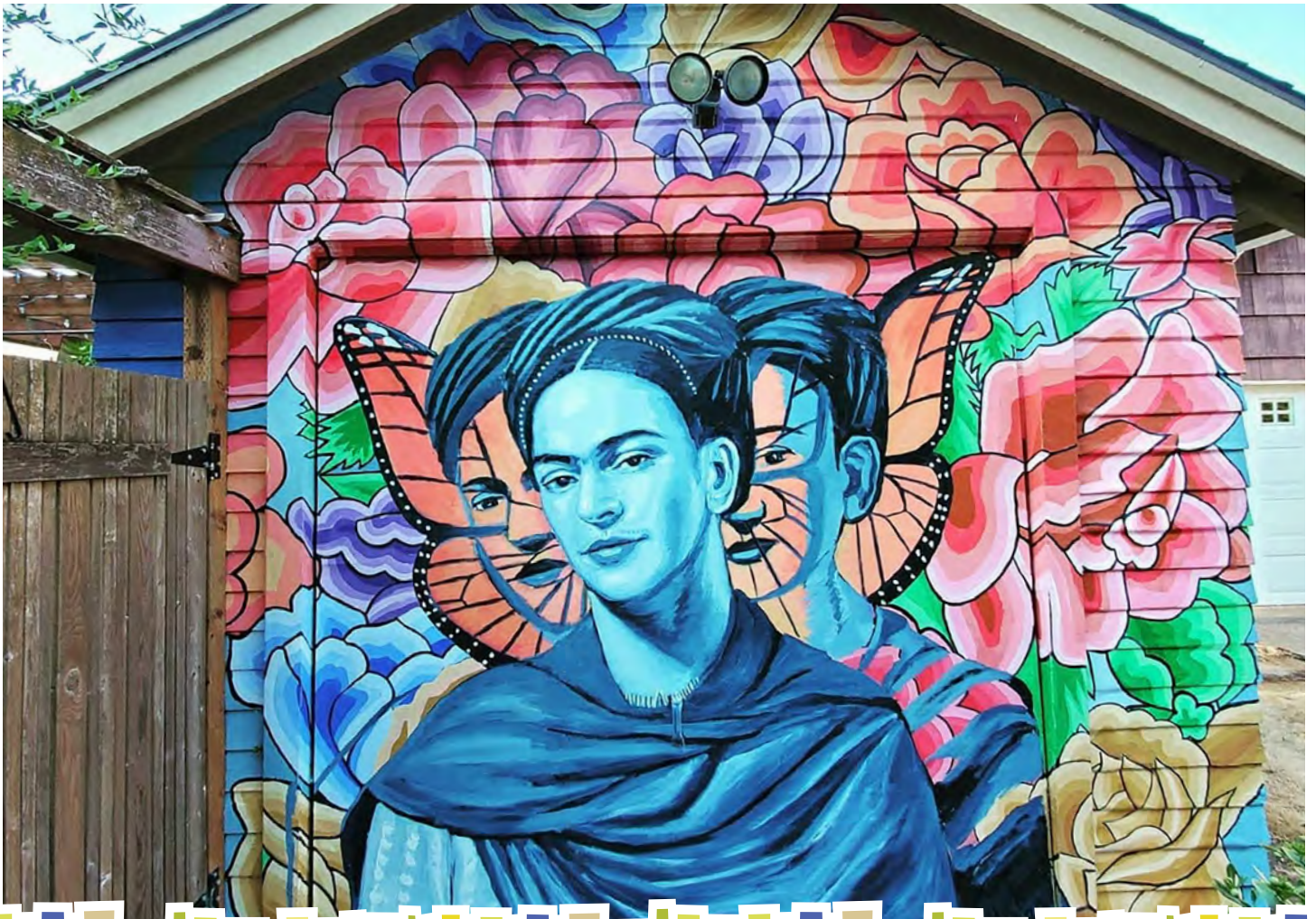
Substance use disorder (SUD): a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress with 10 or 11 diagnostic criteria (depending on the substance) occurring within a 12-month period. The symptoms associated with a substance use disorder fall into four major groupings: impaired control, social impairment, risky use, and pharmacological criteria (i.e., tolerance and withdrawal). (National Institutes of Health, n.d.).



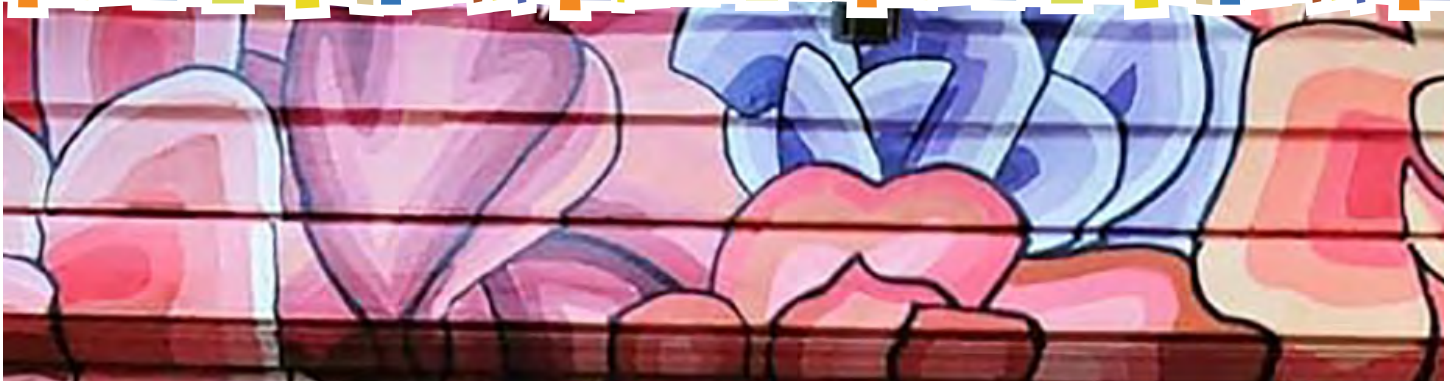
SWOT analysis: a compilation of the strengths, weaknesses, opportunities and threats of an organization. The primary objective of a **SWOT analysis** is to help organizations develop a full awareness of all the factors involved in decision-making. (SWOT analysis, 2020)

Urban, rural, frontier areas:

- **Urban:** The Census Bureau identifies two types of urban areas: urbanized areas of 50,000 or more people and urban clusters of at least 2,500 and less than 50,000 people.
- **Rural:** Geographic areas in Oregon that are 10 or more miles from the centroid of a population center of 40,000 people or more are considered rural.
- **Frontier:** Counties with six or fewer people per square mile are considered frontier. Oregon Office of Rural Health has identified 10 of Oregon's 36 counties as frontier. (Oregon Health & Science University, 2020a)



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Appendices



Adams, Tamara. (n.d.). *Tree Spirit*. [Acrylic on canvas]. Collection of Andrew Constable. New York City, NY. Reprinted with permission.



Appendix 1.

Recommended Modalities and Best Practices in Mental Health & Wellness for Latinos/as/x

By Irma Linda Castillo, MS, Chair of the Oregon Commission on Hispanic Affairs

Establishing use of informed, promising and best practices for unique cultural and linguistic communities is the vanguard for quality care. But, only using culturally specific or recommended modalities is no substitute for culturally and linguistically competent, responsive practice and care of the Latino/a/x community. The effectiveness of excellence in care lies in the combination of these essential elements:

- A skilled provider from the same ethnic, cultural, racial and linguistic background
- Well-resourced, culturally responsive programming
- Culturally humble and competent supervision that uses an equity, empowerment lens, and
- A behavioral health care coordination system that is accessible and actively responsive to the needs of the Latino/a/x community, which connects and funds payment for culturally competent care, community engagement and retention in care.

In this report we have provided recommendations on how to improve and increase the academic and professional pipeline of mental health providers who understand the vital importance and inclusion of Latino/a/x cultural values, history, language, and the challenges of participants' use of mental health and addictions services.

The following is a sample of recommended, promising and best practices in care. In general, the use of traditional/mainstream modalities can be effective when used in combination with the above culturally responsive recommendations, as well as with other culturally specific modalities such as popular education and community health worker models:

Psychoeducation, community health worker outreach and support; classes on stress management, coping skills management, crisis/conflict de-escalation	Popular education in health promotion (Wiggins, 2011, Oxford University Press)
Family and parenting education, family participation in care of participant	Group model education; male, female and non-binary specific, youth, couple, etc.



Best practice treatment modalities for depression, anxiety, trauma, post-traumatic stress disorder (PTSD), domestic violence, psychiatric disorders, etc.	Wraparound services model for children and severe and persistent mental illness (SPMI) population
School-based mental health services, restorative justice models in the school and community	Counseling models for individual, parent-child, marital, grief, crisis debriefing
Herbology, massage, folk healers, pastoral care	Psychiatric consults and medication education
Primary care collaboration and social worker and/or psychiatric services	Community care and follow-up
Home visits	Community outreach, health promotion fairs, resource information
Media and video outreach on stigma and mental health issues	Crisis lines and crisis services in target languages with well-trained culturally responsive staff

The following provides a sample of research on mental health treatment for the Latino/a/x community

1. Best Practice Highlights. Prepared by Lisa Fortuna, MD

<https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights/working-with-latino-patients>

Latino/a/x culture is known for its collectivist-family orientation, the importance of *personalismo* (personal connectedness in interactions) and respect for authority. Conversely, an increase in rates of psychiatric disorders and suicide is seen with increasing acculturation or assimilation into American culture. Being bicultural and bilingual is protective for youth both academically and for mental health. Being able to communicate in the language of both worlds maximizes the child's capacity to draw upon available protective resources while at the same time it enables an adaptive response to the language demand. Conversely, non-linguistic aspects of bicultural competence in the child, family and extended social environment have an important protective role in Latino children of immigrants and minimize their distress.



Examples of Hispanic culture-bound syndromes (Paniagua, F. A., 2000)

Ataque de Nervios: Out-of-consciousness state resulting from evil spirits. See above for a more in-depth description.

Cólera: Anger and rage disturbing body balances leading to headache, screaming, stomach pain, loss of consciousness and fatigue.


Mal de ojo: Medical problems, such as vomiting, fever, diarrhea and mental problems (e.g., anxiety, depression) could result from the mal de ojo (evil eye) the individual experienced from another person.

Susto, Miedo, espanto, pasmus: Tiredness and weakness resulting from frightening and startling experiences.

Wind or cold illness: A fear of cold and the wind; feeling weak and susceptible to illness resulting from the belief that natural and supernatural elements are not balanced.

A few cultural differences between Anglo Americans and Latinos/as/x (Parekh & Trinh, 2019)	
Anglo Americans	Latinos/as/x
Nuclear family-oriented	Extended family-oriented (protective factor)
Do not emphasize supernatural forces	Importance on the spiritual domain (supernatural forces, use of saints as intermediaries)
Autonomy from parental approval as hallmark of optimal adult development	Respect for parental authority persists throughout life, e.g., not talking back
Direct communication	Indirect communication (use of third persons, allusions, proverbs, metaphors, jokes and stories to transmit information)
Business-like (task-oriented)	<i>Personalismo</i> (high level of emotional resonance and personal involvement with family encounters or friends): emotive style, person-oriented, patriarchal (<i>machismo</i>)

For Latinos/as/x, having a mental illness or even receiving counseling can be stigmatizing. Poor access to care due to low rates of insurance, immigration status, language and cultural



barriers in health care that can include differences between provider-patient in explanatory models of illness and families as the gatekeepers can limit entry into treatment (Cortes et al, 2008). Availability of specialized mental health services or comparable integrated behavioral treatment within primary care could improve treatment access and retention.

Spirituality and religiosity are also important frames through which mental health is understood and addressed by many Latinos/as/x. Having a strong religious faith can be protective in reducing suicide attempts and/or decreasing risk of alcohol or substance use disorders for some Latinos/as/x. Visions of spirits and angels do not necessarily imply psychosis. In a study of hallucinatory experiences using a nationally representative data base, Latinos/as/x were more likely to attribute unidentified voices to their hallucinations and explained these experiences as relating to the realm of unidentified spirits, or forces which at times serve as protections or provide ominous warnings. Many of these themes fall into the context of spiritualist belief systems prevalent in many Latinos/as/x cultures and are not considered abnormal or uncommon within those cultures.

A few best practices for working with Latinos/as/x

- A. Use a bio-psycho-social-cultural model of evaluation and treatment.
- B. Take the time to develop a cultural formulation, which includes a consideration for acculturation, community and family connection, immigration status/history, education.
- C. Supporting collaborative care with Latinos/as/x is important for retention and success of care. Although this is a culture that respects authority, feeling misunderstood and not connected to a therapist often results in dropping out from treatment.

A future filled with quality treatment, prevention and early intervention for Latinos/as/x will be best achieved by following six strategies: community partnerships; culturally and linguistically appropriate treatment; workforce development to sustain a culturally and linguistically competent mental health workforce; and community outreach and engagement.

2. Mental health facts for refugees, asylum seekers and survivors of forced displacement

<https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Refugees.pdf>

3. Best practices for mental health interpreters working with Latino/a/x and Hispanics.
May, 16, 2020

<https://mhctcnetwork.org/centers/national-hispanic-and-latino-mhctc/product/best-practices-mental-health-interpreters>



4. Community defined solutions for Latino/a/x mental health care disparities
<https://health.ucdavis.edu/crhd/pdfs/resources/community-defined-solutions-latino-mental-health-care-disparities.pdf>
5. Latino/a/x adults' access to mental health care: A review of epidemiological studies
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2551758/>
6. Mental Health: Culture, race, and ethnicity: A supplement to mental health: A report of the surgeon general. Chapter 6: Mental health care for Hispanic Americans
<https://www.ncbi.nlm.nih.gov/books/NBK44247/>
7. Mental health disparities: Hispanics and Latinos/as/x. Dec. 19, 2017
<https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Hispanic-Latino.pdf>
8. SAMHSA updates, briefs and best practices for mental health and addiction services
<https://www.samhsa.gov/behavioral-health-equity/hispanic-latino>
 - » August and September 2019 (SAMHSA and NNED 2-part series) — [Strategies to Address the Opioid Epidemic in Black and Hispanic/Latinx Communities](#)
 - » July 2019 — [Moving Forward: Diverse Community Perspectives and Strategies on Trauma, Healing, and Trust](#)
 - » April 2019 — [Workplace Environment Matters: Strategies to Support and Retain Behavioral Health Staff Providing Services to Diverse Ethnic and Racial Populations](#)
 - » February 2019 — [Building the Evidence: Innovative Partnerships to Move Community-Defined Evidence to Best Practice](#)
9. Overcoming mental health stigma and integrated services with primary care
<https://consultqd.clevelandclinic.org/overcoming-mental-health-stigma-in-the-latino-community/>
 - » **Removing the language barrier**
Communication is essential to diagnosing mental disorders, so understanding what patients are expressing is critical. Using an interpreter may help, but a psychiatrist who speaks the patient's native language — and can interpret cultural nuances and jargon — is often most effective, says Dr. Lorenzo.



» **Collaborating with primary care physicians (PCPs)**

Since Latinos/as/x with a mental health concern are twice as likely to consult a PCP rather than a mental health provider, collaborating with primary care clinics is vital to reaching this population. “Latinos typically won’t claim they’ve had a panic attack, for example, but they will report the somatic symptoms, like chest pain and shortness of breath,” says Dr. Lorenzo. “PCPs are the ones to identify the psychological root of the symptoms and refer patients for appropriate care.”

» **Encouraging family involvement**

Latinos/as/x have strong family networks, says Dr. Lorenzo. Family support can help alleviate the stigma of a mental disorder and embolden patients to address it. “I encourage my patients to bring their parent, spouse or child to their appointments,” she says. “Sharing information with family members increases their understanding of the disease and helps them better support the patient.”

» **Offering sensitive, culturally competent treatment**

Schizophrenia, bipolar disorder and similar severe mental illnesses are especially stigmatizing — labeled “*locura*” (Spanish for “craziness”) by many Latinos/as/x. More common disorders, such as depression and anxiety, are regarded as merely “*nervios*” (“nervousness”) and perceived as short-term, easier to treat and not requiring medication. As such, Dr. Lorenzo is cautious about recommending pharmacotherapy to her patients. “Latinos tend to view psychotherapy as more acceptable,” she says. “If appropriate, I often recommend that first, then add medication later if needed.”

» **Educating about the physiologic roots of mental illness**

Lack of information and misunderstanding fuel the stigma. Providing details about diagnoses, discussing treatment options and answering questions may be the best way to eradicate stigma. “Explaining the biological underpinnings of mental health disorders is enlightening to many Latinos,” says Dr. Lorenzo. “When they understand that chemicals in the brain play a primary role, they view the diseases differently.”

Helping Latinos/as/x overcome their community’s stigma about mental illness is difficult. But the more that physicians understand Latino/a/x culture and work to raise awareness of mental health disorders and symptoms, the better.

“When a Latino patient does disclose information indicating possible depression, anxiety or another mental health concern, we need to address it immediately,” says Dr. Lorenzo. “For them to open up, they must really be struggling.”



10. Best practice mental health services school-age Latino/a/x youth

<https://www.wnpr.org/post/school-based-mental-health-centers-play-vital-role-hispanic-and-black-students>

Taking a cultural approach to mental health, evidence based culturally informed promising practices

<https://www.unidosus.org/research/articles/latino-youth-mental-health-services-122016>

<https://mhctcnetwork.org/sites/default/files/2019-10/INFOGSB.pdf>

Appendix 2. Artists' biographies

Tamara Adams has exhibited her work in galleries and juried art events for more than 30 years. Her colorful acrylic and mixed media paintings pay tribute to the beauty, mystery and strength of the feminine spirit. With a wide range of cultural and creative influences along with a feminist leaning, her body of work has grown into an eclectic fusion of themes that embrace, celebrate and value diversity. View more of her art at www.tamaraadamsart.com.

“Daniel DeSiga painted brightly colored murals of the Latino experience and lifestyle — always incorporating images that highlighted a love of his native Pacific Northwest — on walls from Toppenish and Fresno, Calif., to the historic El Centro de la Raza in Seattle.” *A colorful life: Latino artist Daniel DeSiga remembered.* [DIAN VER VALEN of the Walla Walla Union-Bulletin](#), April 20, 2020. Updated Aug 24, 2020.

DeSiga is also known for his silkscreen painting for the Colegio Cesar Chavez (1975—1985) (see page 121) in Mt. Angel, Ore. When the Colegio received its accreditation in 1975, it was the only independent Chicano college in the country. DeSiga was chairman of the art department when he created it. The Colegio itself was the creation of many Latinos/as/x in Oregon (and allies) struggling for social justice in the 1970s.

Hector H. Hernandez's first experience painting murals occurred in Mexico City while he was studying social anthropology. He participated as a collaborator for two murals under the guidance of the Mexican Master painter Arnold Belkin. This experience allowed him to follow the path to community murals from the teachings of the Mexican school of painting. Since then, the academic training that he gained in painting murals has focused on community murals with an academic background, so he can reach new generations of painters and community artists.



He received his master's in fine arts degree from the University of Oregon in 1999 in painting. He also received a master's degree in art and education and bachelor's degrees in fine arts and social anthropology.

Since 1997 the focus of his work has been providing mural workshops as artist in residence. Such activities include an instructional aspect and the delivery of a mural for the institutions requesting the mural work. He also has worked on several mural media such as parachute cloth, tiles and mosaics. Recently stained glass and other materials have been incorporated into his mosaic work including art objects. Hernandez has also worked with clay and other mixed media pieces. His art objects have resulted from mixed media, seen in murals in Portland and Woodburn. The subjects and themes in his works have addressed cultural and social issues such as social and cultural change, immigration and cultural interactions and dynamics. Such topics and others related to art have been delivered in several formats at universities and K–12 courses. For more information, go to www.hectorrh.com and www.behance.net/hectorrh.

William Hernandez is a Portland-based painter whose artwork creates a bridge spanning his past traditions and memories to his life today as an artist, family man and Peruvian living in the Pacific Northwest. Trained as a painter at Lima's Escuela Nacional de Bellas Artes (1995–2002), Hernandez worked as a fine artist and graphic designer for public and international institutions in Lima before settling in Portland in 2009. His surreal subjects and graphic, illustrative style creates layered narratives infused with lingering emotions from whimsy to melancholy.

Hernandez is an active artist, teacher and organizer in the Pacific Northwest. He was one of the organizers for the first Intercambio de Artistas Latinos (Latin American Artists Exchange), which aims to create a network of artists in the Northwest to share ideas, expression and art. He has been an exhibitor, artist-in-residence and instructor at Milagros Theater in Portland, a hub of the regional Latino/a/x community. As a teacher, he is dedicated to introducing the arts to all ages, from working as a fine art painting instructor at the Museum of Art in Lima, to creating bilingual Spanish/English children's workshops and organizing painting classes for immigrant workers at VOZ Workers Rights Education Project in Portland.

Hernandez's vibrant paintings have been exhibited in galleries and cultural centers from Peru to Portland, including Instituto Cultural Peruano Norteamericano, Centro Cultural de Espana, Concordia University, Onda Gallery in Portland and ArtXchange Gallery in Seattle. For multiple years, he participated in the U.S. Embassy's Noche de Arte, which is the largest art exhibition in Peru; it generates funds for the United States Agency for International Development (USAID). Hernandez's



artworks are in private collections in Australia, Belgium, Chile, France, Germany, Guatemala, Peru, Spain and the United States. Go to www.williamhernandezart.com for more information.

Lilia Ramirez (Liliflor Art) was born and raised in Los Angeles. Her inspiration comes from her upbringing, family, community and underground cultural movements. As a first generation Mexican American “Chicana,” she navigated through L.A.’s art scene during the ‘80s and ‘90s hip hop movement. Graffiti subculture was a critical part in her development, inspiration and path toward a professional art and educational career. Liliflor hones her artistic ability to create vital images on canvas and walls that are representative of Angelinos. She is a cultural art educator championing youth in the arts, using art as a tool for education, cultural awareness, civic engagement, healing and transformation.

Lilia’s strength lies in her bold approach in integrating Nahuatl cosmology aesthetic experimentation. She brings knowledge of her indigenous roots to bear in her work that dignifies the everyday people of Los Angeles. Her artwork weaves various subjects such as spiritual, urban environments, women, children, indigenous cosmology and culture. Aesthetically, Lilia’s work reproduces familiar visual symbols and iconography that enable her to create a composition of multilayered visuals and storytelling. The themes in her fine art and murals combine ideas inspired by the communities she serves as an artist, muralist and educator. The lively color schemes bind the iconography with the subject matter and composition. See more at www.liliflorart.com.

Henry A. J. Ramos is a California visual artist whose multi-media works have shown and sold in California, New York and Europe. His images, typically child-like and vibrant in color, are overlaid with subtle but purposeful messaging on issues ranging from social justice to environmental responsibility. Ramos has been affiliated over the years with the Gallery of Graphic Arts in New York City and Studios on the Park in Paso Robles, CA. He is a former board member of the Romare Bearden Foundation. Ramos is also a former advisor on arts and culture projects involving the works and collections of the late, world-renowned Mexican muralist Diego Rivera and former U.S. Vice President Nelson A. Rockefeller.

To contact Ramos, his email address is mauerkunst.principal@gmail.com.

Appendix 3. OCHA/OHA/ODHS research internships*

Hispanic Mental Health Services

OHA/OCHA Joint Public Policy Research Internships: Summer or Fall

* Research internship descriptions included in this report reflect the OAC membership and language that was current at the time the description was written.



Researching mental health services disparities of the Hispanic communities in Oregon, associated consequences and strategies to address gaps

Joint internship partners:

- OACO/Oregon Commission on Hispanic Affairs (OCHA)
- Oregon Health Authority (OHA)
- Office of Equity and Inclusion (OEI), a division of OHA
- Oregon Department of Human Services (ODHS)
- Governor's Offices of Diversity and Community Engagement

OHA based internship on researching health disparities of Hispanic communities in Oregon in the mental health services, the specific experiences and consequences of those health disparities and the strategies to address the services gaps of Hispanic communities in Oregon statewide.

Background and need: Mental health services are one of the strategic health care priority areas for the Oregon Health Authority according to the new CMS Waiver. A recent 2012 state audit of the Medicaid-funded Oregon Health Plan showed that Hispanic youth were using mental health services at a disproportionately low rate.* With a growing number of bilingual, and limited English proficiency members of the Oregon Health Plan, language access support service should match

* http://www.sos.state.or.us/audits/pages/state_audits/full/2012/2012-16.pdf

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the new volume of care needed in every community in the state. Mental health service needs are at capacity and more research is needed to find ways to bring more professionals in shortage areas and especially bilingual and bicultural services providers to meet those needs.

Research topics might include but not limited to data on Spanish speaking mental health professionals, Hispanic student enrollment in mental health training programs, waiting times for Hispanic patients, and length of stay from mental health emergencies.* This research will inform policy discussions already begun in leadership circles within state and county government, health care, culturally specific communities, and other key partners. At a time when many in the Hispanic communities are facing immigration enforcement action, we are concerned with the cumulative effects this may have, increasing stress, PTSD and other mental health risks to families and communities.

Requirements: A Masters or PhD student pursuing a Public Policy, Social Work, Public Health, I/O Psychology related degree with 6-8 credits related to data analysis and statistics for summer or fall, 2017.

The research: This internship will include a review of national and Oregon best practices; statutory or administrative barriers, lessons learned, a needs or gap analysis and suggested next steps. The health disparities in mental health, access to services for Hispanic OHP members, language and other barriers that are preventing mental health care from being more accessible will be identified by this research. Alberto Moreno, MSW, Chair of OCHA and CEO of the Oregon Hispanic Health Coalition, will work with the student to develop appropriate research questions. Mr. Moreno will support the student to engage in policy discussions with the Oregon Health Authority and other leaders in the state legislature. The Oregon Health Authority and the Department of Human Services will serve as advisors to the student on policy and provide appropriate access to data. The sitting legislators who are members of OCHA will mentor the student on ways this research is useful to the legislative process. The research and data will be presented to the OCHA, the OHA Office of Equity and Inclusion and Department of Human Services. The final report will be included in the OCHA Biennial Report to the Governor and the Legislature with recommendations for policy development, training and possible legislative action. The selected Intern will have 6–8 credits related to data analysis and statistics or a waiver of such due to demonstrated competency.

* L.J. Cabassa, L.H. Zayas, M.C. Hansen. Latino adults' access to mental health care. (2008), Retrieved 2020 Dec 6, from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2551758/>.



Supervision: The intern will develop their course of study and work plan with their major professor as a for-credit experience. The selected student will work with Alberto Moreno, MSW, OCHA OCHA Chair; Serena Stoudamire Wesley, Governor's Director for Diversity and Community Engagement; Leann Johnson, Director of the Office of Equity and Inclusion, a Division of OHA; and legislative members of the OCHA, to study strategies that health systems, counties and states have used to address the health care disparities of mental health care services in the Hispanic communities.

Deliverables: The research intern will prepare and present a documented report on the findings and analysis to the OCHA and the OEI within the Oregon Health Authority. A short (5 minute) and long (20 minute) presentation will also be prepared and may be presented to Oregon legislative committees at the request of partnering legislators.

The Advocacy Commissions' Reports to the Legislature are statutory reports produced by each of the four advocacy commissions biennially prior to legislative session. Commissions are Governor-appointed bodies of nine eminent community members and two legislators appointed by the President of the Senate and Speaker of the House respectively, who advise the Governor and legislature on key issues to the Asian Pacific Islander, Black, Hispanic communities and Women and guide policy to address the concerns of these under-represented constituencies in Oregon. Mental health disparities are long standing concerns of the Commissions.

Public policy internships with the Oregon Advocacy Commissions are unpaid and count as credit toward the intern's degree

Contact information and application due date: Interested students send a resume and cover letter expressing their interest to Lucy Baker, Administrator, Oregon Advocacy Commissions Office (OACO) lucy.baker@oregon.gov. Resume and cover letter due no later than Monday, May 1, 2017.

The intern will work 6-8 hours per week over the course of spring semester 2017. Bilingual and bicultural students encouraged to apply. Physical location may be in Portland, Salem or other.



Immigrant Credentials Integration

Joint Public Policy Research Internship

Strategies for integrating the skills and credentials of Oregon immigrants into the workforce

Joint internship partners:

- OACO/Oregon Commission on Asian and Pacific Islander Affairs (OCAPIA)
- Partners in Diversity (PID)
- Oregon Workforce Investment Board (OWIB)
- Governor's Offices of Equity and Workforce
- PSU Applied Linguistics Department

Internship on researching alternatives to and within the TOEFL (Test of English as a Foreign Language) as part of licensing requirements in specific professions, exploring Oregon specific data on TOEFL takers, and investigating/ comparing best practices of states and Canada for pathways to professional license or trades certification for professionals who are immigrants.

Background and need: Many immigrants from Asian, African, Middle Eastern and other countries bring their professional credentials to their new home in Oregon with the expectation that they will be able to work in their fields. These individuals include physicians, skilled nurses, psychiatrists, machine operators,

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electricians, among others. However immigrants with these specialized skills can often land only minimum wage, low skill jobs because their internationally earned degrees and credentials have no efficient path to equivalent credentials in Oregon.

Oregon and its communities need these important and sought after competencies and these individuals' expertise in every part of the state. This research will inform policy discussions already begun in leadership circles within state and county government, higher education, immigrant communities, and other key partners.

Requirements: A Masters or PhD student pursuing a public policy related, applied linguistics or education degree, or 3L Law student focusing on employment law.

The research: This internship will include:

1. Collecting data from ETS
 - » Discover and collect (if available) Oregon specific data on TOEFL test takers which may include profession, country of origin, native language, number of times taken the test, scores by TOEFL sub-section, performance over time by specific variables and other analytics available from ETS.
 - » Discover whether ETS has created any evaluations for specific professions and whether they have interest in such pursuits.
2. Develop an inventory of national and state credentialing organizations and determine if standards are set at the state or national level or combination
 - » Relevant profession
 - » Credentialing body
 - » Specific requirement(s) re TOEFL and TOEFL sub-scores for credentialing
3. US national best practices
 - » Investigate what other states have done, including Michigan, to facilitate credentialing, creating pathways for international professions including the role of Executive Orders and what was done differently after this or other policy changes.
 - » Determine success measures and progress for each best practice.
4. Determine Canada's process and pathways, and measures
 - » Develop a chart comparing Canadian language benchmarks with US language proficiency requirements.

- 
- » Develop a briefing sheet of two pages regarding the primary model, and success measures, and other informational comparison between Canadian and US efforts.
 - 5. Prepare a final report and associated PowerPoint presentation for policymakers of the elements and findings of this research, and identify areas of promise for Oregon around policy remedies, best practice, needed coalition building and key stakeholders essential for success.

Supervision: The intern will develop their course of study and work plan with their major professor as a for-credit experience. The selected student will work with Chanpone Sinlapasai, JD, OCAPIA Commissioner; Mari Watanabe, Executive Director of Partners in Diversity; Serena Stoudamire Wesley, Governor's Director for Equity and Community Engagement; Elana Pirtle-Guiney, Governor's Policy Advisor on Workforce; and Sen. Michael Dembrow, OCAPIA Commissioner and member of the Oregon Workforce Investment Board, to implement the scope of work and receive mentoring during their project on the implications and presentation of their research to policymakers and business in Oregon. PSU Applied Linguistics is part of the research support for this project and will provide input and mentoring for the student as requested.

Deliverables: The intern will prepare and present a documented report on the findings and analysis to the OCAPIA, and a legislative or state policymaking body. Along with the final report, a short (5 minute) and long (20 minute) slide presentation will also be prepared and may be presented to Oregon legislative committees at the request of partnering legislators.

About the Internship: Public Policy Internships/Externships with the Oregon Advocacy Commissions are unpaid and count as credit towards the intern's degree. Schools may have stipends available that are arranged separately from the OACO.

The intern will work 8-20 hours per week over the course of a quarter or semester beginning in the spring or summer of 2018. The final count of hours will be decided by the student and his/her major professor, in line with the credits to be earned, the length of the course, and the scope of work to be completed. The hours will be finalized in communication with Lucy Baker, Administrator of the Oregon Advocacy Commissions.

The Oregon Advocacy Commissions Office is based in Portland, OR, but the intern may work with the sponsors to be based in Salem or a state office near their school.

The Advocacy Commissions' Reports to the Legislature are statutory reports produced by each of the 4 Advocacy Commissions prior to legislative session. The Commissions are equity focused public policy bodies of nine eminent community members appointed by the Governor, and two

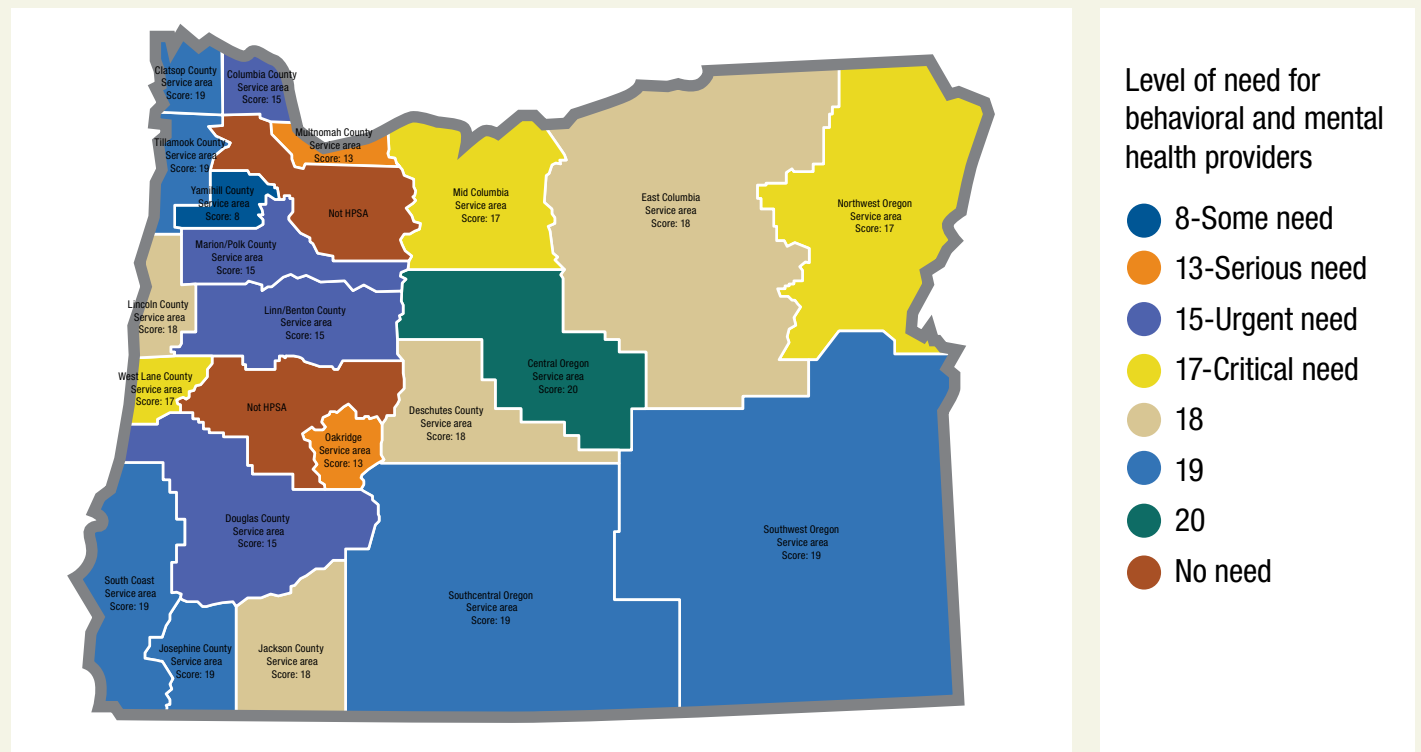
legislators appointed by the President of the Senate and the Speaker of the House, respectively, which advise the Governor and legislature on issues of importance to the Asian/API, Black, Hispanic communities and Women. Statutorily, the Oregon Advocacy Commissions guide and research equitable policy addressing the success of under-represented constituencies in Oregon. Workforce participation and access to training are long standing priorities of the Commissions. <http://www.oregon.gov/oac/pages/index.aspx>

Contact information

Interested interns/externs please send Lucy Baker, Administrator, Oregon Advocacy Commissions Office (OACO), a resume and cover letter expressing their interest to lucy.baker@oregon.gov. She can also be reached at 503-250-2698.

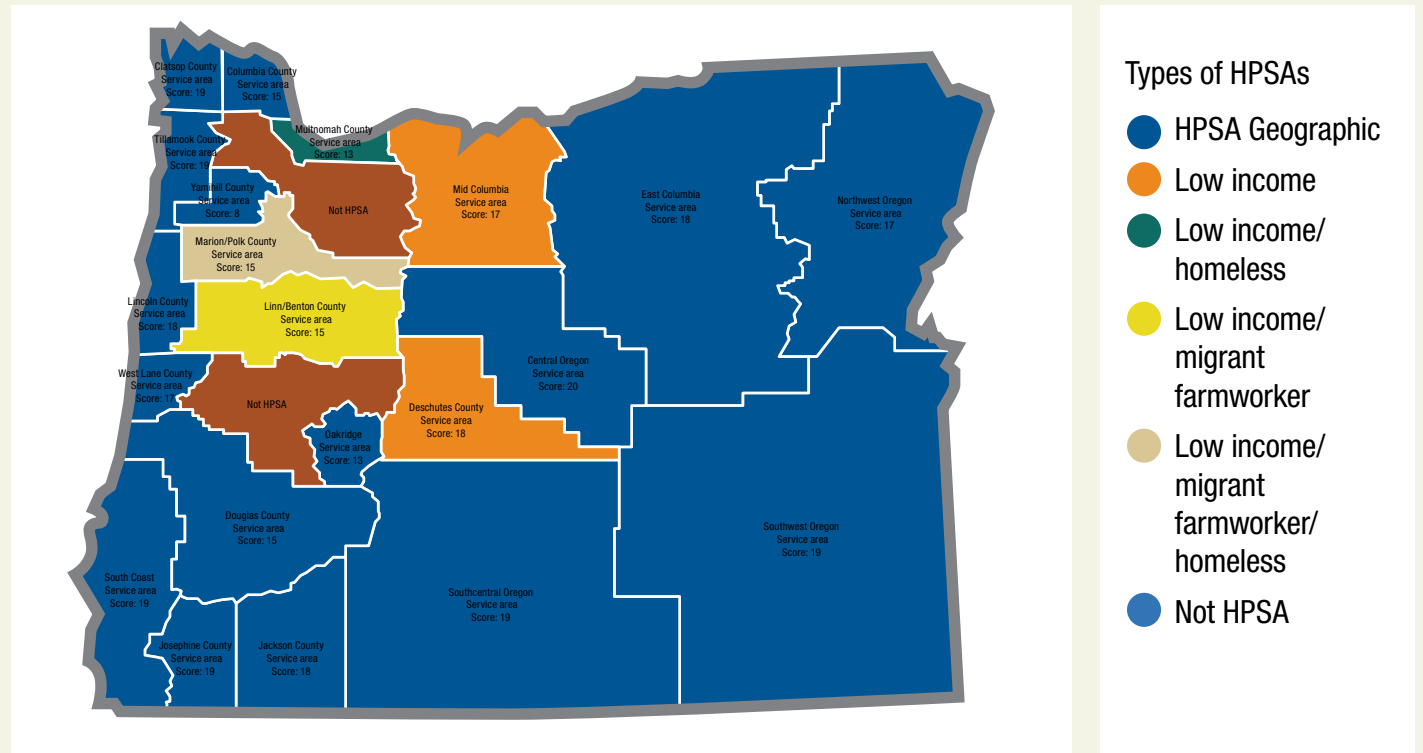
Appendix 4. Designated health professional shortage areas in Oregon

Figure 34: Behavioral and mental health professional shortage areas by score, 2017



(Oregon Health Authority. Behavioral Health Services)

Figure 35: Behavioral and mental health professional shortage areas by type, 2017



(Oregon Health Authority. Behavioral Health Services)

Appendix 5. Hyperlinks for OCHA, OHA and ODHS's joint policy research reports and presentations

Study title	Author	Type	Total	Description of sample
Mental Health Disparities for Latino Oregonians - Report Mental Health Disparities for Latino Oregonians - Presentation	Kimberly Voelker, MPH	Quantitative	N=272,538	Oregonians who initiated mental health care between 1983 & 2013 and terminated between 2010 & 2014 who utilized state-sponsored insurance
Mental Health Service Disparities of Latino Oregonians: A Qualitative Analysis - Report Barriers to Mental Health Service Latinos in Oregonian: A Qualitative Analysis - Presentation	Diana St. Amour, MSW	Qualitative	N=16	Mental Health Providers – urban + rural
Mental Health Service Disparities in the Latino Population - Report Mental Health Service Disparities in the Latino Population - Presentation	Erin Hernandez, MS	Literature Review	N/A	Rural focus
Access & Barriers to Mental Health Services for Oregon's Latino Population - Presentation	Rebecca Honda, MSW	Qualitative	N=8	Mental Health Providers – Rural



Our vision:

We serve the people of Oregon to empower and support Latinos through our special roles as policy advisors to Oregon state policymakers and leaders. The OCHA is a catalyst that empowers partnerships between state government and Hispanic communities in rural and urban areas to ensure success for all Latinos by addressing issues at the policy level.

Our mission:

Organized in its current role under Governor Atiyeh, and serving seven administrations, the mission of the Oregon Commission on Hispanic Affairs is to work toward economic, social, political and legal equality for Oregon's Hispanic population.

Our principles and values:

- Equity for Hispanic Oregonians in jobs and the economy, education, health, safety, family stability, environment, and civic engagement.
- Equal treatment and protection against discrimination.
- Access to helpful information on services and available resources.
- Working in partnership on research and policy analysis of longstanding issues and barriers to success within the Hispanic community statewide.
- Inclusion of viewpoints of the Hispanic community in policymaking at the state level.
- Celebration of and awareness about the contributions and achievements of Hispanic Oregonians.

Our statutory goals and strategic priorities:

- Advocate for equitable policies assuring the success of Latino and Hispanic Oregonians at the state level.
- Engage community and state partners to promote equity for Latinos statewide.
- Study and analyze issues affecting the Hispanic community statewide and recommend policy remedies to state policymakers.
- Grow and develop leaders the Hispanic community at the state level in all branches.
- Increase the viability and visibility of the contributions and achievements of Hispanic Oregonians statewide.
- OCHA's strategic priorities: Education, Jobs and the Economy; Safety, Justice and Policing; Housing and Stable Families; Health and Healthcare; Civic Engagement; and Environmental Justice

You can get this document in other languages, large print, braille or a format you prefer. Contact the Oregon Advocacy Commissions Office at 503-302-9725 or email OACO.mail@oregon.gov.